COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

December 22, 2008

ADDENDUM No. 4 TO VENDORS:

Reference Request for Proposal: **RFP 2009-02**
Dated: **November 21, 2008**
Due: **January 20, 2009**

RFP change: The due date for receipt of proposals is hereby extended to January 20, 2009 at 2:00 PM local time.

Note: Commonwealth of Virginia offices will be closed Friday January 16, 2009 and Monday January 19, 2009

Attached is a revised RFP 2009-02 with references to VALTC removed. The RFP has "Track Changes" on to give all Vendors exact changes regarding the removal of VALTC. The VALTC program will not be implemented as part of RFP 2009-02. Therefore any activities that were listed in RFP 2009-02 for VALTC are hereby deleted from the RFP. If the RFP activity was required for multiple populations/programs (i.e., MEDALLION and Medallion II and VALTC) the activity remains a requirement for the RFP referenced populations/programs other than VALTC. Further, any inter-related costs associated with the VALTC program (for example - office space, etc.) should be removed from the Offeror's cost proposal.

Note: A signed acknowledgment of this addendum must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

William D. Sydnor

William D. Sydnor
Contract Management Director

Name of Firm: _____

Signature and Title: _____

Date: _____

COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

600 East Broad Street, Suite 1300
Richmond, VA 23219

November 21, 2008

Dear Prospective Vendor:

The Department of Medical Assistance Services (DMAS) is soliciting proposals from qualified Enrollment Broker firms for the education and enrollment of Medicaid eligibles into the Virginia Medicaid/FAMIS Plus mandatory and voluntary Managed Care Programs. Duties of the Contractor shall include Enrollment Broker and education services. Specific details about this procurement are in the enclosed Request for Proposal RFP 2009-02. The selected contractor(s) will provide the required services for The Department of Medical Assistance Services. Contractors must check the web site at www.dmas.virginia.gov or check the eVA web site at www.eva.virginia.gov for any addendums or notices regarding this RFP.

The Commonwealth shall not pay any costs that any Contractor incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Contractors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Susan Offie, Contract Monitor, Managed Care Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to ebrfp@dmas.virginia.gov.

Contractors who wish to submit a proposal are required to submit a Letter of Intent which must be received by the Department no later than 2:00 PM local time on December 2, 2008. The prior submission of a Letter of Intent is a prerequisite for submitting a proposal; proposals shall not be accepted from Contractors who have not submitted a Letter of Intent by the deadline specified above. Letters of Intent shall be sent to:

Department of Medical Assistance Services
Attention: William D. Sydnor
600 East Broad Street, Suite 1300
Richmond, VA 23219

Sincerely,

William D. Sydnor

William D. Sydnor
Contract Management Director

Enclosure

REQUEST FOR PROPOSALS
RFP 2009-02

Issue Date: November 21, 2008

Title: Enrollment Broker and Education Services

Period of Contract: Three years from award of contract, with provisions for three (3), one-year (1) extensions.

All inquiries should be directed in writing via email in MS Word Format to: ebrfp@dmas.virginia.gov

Susan Offie, Contract Monitor
Managed Care Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
ebrfp@dmas.virginia.gov

Deadline for submitting Letter of Intent and inquiries is **2:00 pm Local Time. December 2, 2008**

Proposal Due Date: Proposals will be accepted until **2:00 p.m. Local Time. on January 6, 2009.**

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

"RFP 2009-02 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: William D. Sydnor

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone	Date Signed
Fax Number	
eVA Registration Required	eVA Vendor #:
Check Applicable Status Corporation ---------- Partnership --------- Proprietorship -------- Individual ------ Woman Owned ---------- Minority Owned ---------- Small Business --------- If DMBE certified, provide certification number:	

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

ENROLLMENT BROKER AND EDUCATION SERVICES

RFP 2009-02

ISSUED: November 21, 2008

TABLE OF CONTENTS

RFP 2009-02 – ENROLLMENT BROKER AND EDUCATION SERVICES

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Deleted: 17
Deleted: 18
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Deleted: 18
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Deleted: 98
Deleted: 98
Deleted: ATTACHMENT XIII ... [3]
Deleted: 101
Deleted: 101
Deleted: ATTACHMENT XV - ... [4]
Deleted: 103
Deleted: 103
Deleted: 104
Deleted: 104
Deleted: 105
Deleted: 105
Deleted: 107
Deleted: 107
Deleted: 108
Deleted: 108
Deleted: 109
Deleted: 109
Deleted: ATTACHMENT XXII ... [5]
Deleted: 111
Deleted: 111
Deleted: 112
Deleted: 112
Deleted: 113
Deleted: 113
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1. PURPOSE AND DEFINITIONS

The Commonwealth of Virginia, acting through its Department of Medical Assistance Services (DMAS), hereinafter referred to as the Department, is committed to offering Medicaid and FAMIS Plus eligible recipients a choice of managed health care plans and programs. It is the intent of the Department to solicit proposals from Offerors who wish to contract with the Commonwealth under a fixed-based contractual arrangement. Qualified organizations shall be capable of providing the Department with comprehensive Enrollment Broker/Education services which will both educate Medicaid eligibles about their managed care options and assist Medicaid eligibles in enrolling into managed care programs. Proposals will be based on the Enrollment Broker responsibilities and proposal submission requirements set forth in this Request for Proposal (RFP 2009-02). The selected Enrollment Broker will provide the services required in this RFP; in an efficient and effective manner; within Federal, State, and DMAS requirements; ensuring the highest standards of performance, program integrity, and customer service; at a reasonable cost to the Commonwealth. Following evaluations of the proposals received as a result of this RFP, the Department will conduct competitive negotiations. The Department intends to make a single award as a result of this RFP.

Duration of Contract

The duration of the contract resulting from this RFP is three (3) years from award of contract. This contract may be renewed by the Commonwealth upon written agreement of both parties for up to three (3) successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

Definitions

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

- **Administrative Provider Identifier (API)** – A unique 10-digit identification number issued to providers by DMAS. An API number is issued for non-health care (atypical) providers, for providers who do not submit HIPAA standard transactions to DMAS, and for providers in an MCO network who do not participate with Medicaid.
- **Adverse Action**: Denial or limited authorization of a service; reduction, suspension or termination of a previously authorized service; or denial of a payment in whole or in part for a covered service.
- **Annual:** For the purposes of reporting requirements for the contract, resulting from this RFP, annual shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
- **Appeals:** In accordance with 42 CFR 438.400, an appeal is defined as a request for review of an action, as adverse action is defined in this RFP.
- **Business Days**: Monday through Friday, 8:30 AM to 6:00 PM, Eastern Standard Time, unless otherwise stated.

- **Calendar Year**: January 1 through December 31.
- **Centers for Medicare and Medicaid Services (CMS):** The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.
- **Choice Counseling:** As defined by CMS, this includes activities such as answering questions and providing information (in an unbiased manner) on available MCO or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider.
- **Claim**: An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-92.
- **Client, Recipient, Enrollee, Member or Participant:** An individual having current Medicaid/FAMIS Plus eligibility who shall be authorized by the Department to participate in the Virginia Medicaid program.
- **Complaint:** A grievance.
- **Contract Modifications:** Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations as per Section 9.15.
- **Contract:** The signed and executed document resulting from this RFP, including all attachments or documents incorporated by reference.
- **Contractor:** For the purposes of this RFP, the Enrollment Broker that has entered into an agreement with the Department to provide enrollment services under a fixed-based contractual arrangement.
- **Cultural Competency:** A competency based on the premise of respect for individuals and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.
- **Department:** The Virginia Department of Medical Assistance Services (DMAS).
- **Disenrollment:** The process of changing enrollment from one MCO plan to another MCO or to the Department's Primary Care Case Management (PCCM) program, if applicable.
- **Dual Eligibles:** Medicare beneficiaries who are also enrolled in the Medicaid program.
- **Enrollee:** A Medicaid recipient who is currently enrolled in a MCO or PCCM in a given managed care program. (Also see potential enrollee and Medicaid/FAMIS plus enrollee)
- **Enrollment:** The determination by local Department of Social Services of an individual's eligibility for Medicaid or FAMIS Plus and subsequent entry into the Virginia Medicaid Management Information System (VAMMIS).
- **Enrollment Activities:** Activities such as distributing, collecting, and processing enrollment materials and taking enrollments by mail, phone, or person, as further described in Section 3.
- **Enrollment Area:** The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate and in which service capability exists as defined by the Commonwealth.
- **Enrollment Broker:** An independent entity that performs choice counseling and enrollment activities through the operation of a toll-free recipient service helpline in accordance with 42 CFR 438.810 and as detailed in Sections 3 and 4 of this RFP.
- **Enrollment Services:** Choice counseling and enrollment activities as detailed in Section 3.
- **EPSDT:** The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA

89) legislation and includes periodic screening, vision, dental and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population.

- **Exclusion:** The removal of an enrollee from a program on a temporary or permanent basis.
- **FAMIS:** Family Access to Medical Insurance Security Health Insurance Program.
- **FAMIS Enrollee:** Persons enrolled in the Department's FAMIS program who are eligible to receive services under the State Child Health Plan under Title XXI, as amended.
- **FAMIS Plus Enrollees:** Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities. Additionally, for the terms of the Enrollment Broker contract, FAMIS Plus and Medicaid enrollees are treated in the same manner. Any member materials must appropriately addresses the entire intended population. All enrollment and benefit materials that specify "Medicaid" must also specify "FAMIS Plus". If the material does not specify "Medicaid", it does not need to specify "FAMIS Plus"
- **Fee-for-Service:** The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
- **Fiscal Agent:** A contracting organization which assumes all or part of the State Medicaid Agency's responsibilities with respect to claims processing, provider enrollment and relations, utilization review, and other functions. Synonymous with Fiscal Intermediary.
- **Fiscal Year (State):** July 1 through June 30.
- **Grievance:** In accordance with 42 CFR 438.400, grievance means an expression of dissatisfaction about any matter other than an "action". Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process.
- **Health Insurance Portability & Accountability Act of 1996 (HIPAA):** Standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care facilities, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
- **Health Plan:** Managed Care Organization (MCO) or MEDALLION PCCM program.
- **Implementation Date:** The effective date of the contract.
- **Informational Materials:** Written communications to enrollees that educates and informs about services, policies, procedures, or programs specifically related to MEDALLION, Medallion II.
- **Initial Implementation:** The first time a program or a program change is instituted in a geographical area by the Department.
- **Managed Care Organization (MCO):** In accordance with 42 CFR 438.2, an entity that has qualified to provide the services to qualifying Medallion II enrollees.
- **Marketing Materials:** Materials that are produced by or on behalf of an MCO; are used by the MCO to communicate with individuals who are not its enrollees; and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.
- **MEDALLION Program:** A mandatory primary care case management program (PCCM) delivered through DMAS where a recipient's health care is managed by a primary care provider (PCP) and providers are reimbursed on a fee-for-service basis for all covered services rendered and the PCP is reimbursed $3 per recipient per month (PMPM).

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- **Medallion II Program:** A fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program in which qualified Medicaid/FAMIS Plus recipients choose between at least two contracted Managed Care Organizations. the contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the recipient.
- **Medicaid/FAMIS Plus Enrollee**: For purposes of this contract, any person identified by the Department as being eligible for services.
- **Monthly:** For the purposes of reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.
- **National Provider Identifier (NPI)** - A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). All individual HIPAA covered healthcare providers or organizations must obtain an NPI for use in all HIPAA standard transactions, even if a billing agency prepares the transaction.
- **Offeror:** A person who makes an offer in response to a Request for Proposal.
- **Open Enrollment:** Time frame defined by CMS and the Department as 60 days prior to the end of the recipient's managed care enrollment. Before this 60-day time frame, recipients must be notified of their ability to disenroll or change plans at the end of their enrollment period.
- **Out of Network Coverage:** Coverage provided outside of the established MCO network; medical care rendered to an enrollee by a provider not affiliated with the MCO Contractor or contracted with the MCO.
- **Potential Enrollee**: A Medicaid/FAMIS Plus recipient who is subject to mandatory enrollment in a given managed care program, but is not yet an enrollee of a specific MCO or PCCM. [42CFR438.10(a)].
- **Primary Care Case Management (PCCM):** The MEDALLION system under which a primary care case manager contracts with the Commonwealth to furnish case management services to recipients.
- **Primary Care Provider (PCP):** A practitioner who provides preventive and primary medical care for eligible recipients and who certifies prior authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (FHCs), etc.
- **Protected Health Information (PHI):** Individually identifiable patient information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.
- **Quarterly:** For the purposes of reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
- **Quarters:** Calendar quarters starting on January 1, April 1, July 1, and October 1.
- **Recipient:** See Medicaid/FAMIS Plus enrollee.
- **Secure email:** The generic term that usually applies to sensitive email being passed over the Internet in some form of encrypted format.
- **Shall:** A mandatory requirement or a condition to be met.
- **State:** Commonwealth of Virginia.

- **Subcontractor:** A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities.
- **Virginia Medicaid Management Information System (VAMMIS):** The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services.
- **Virginia Medicaid Policy:** Includes the State plan, regulations, manuals and Medicaid memoranda.

Deleted: <#>**Virginia Acute and Long-Term Care Services (VALTC):** A mandatory Medicaid managed care program that provides primary, acute, and long-term care services through one coordinated delivery system. Participants of VALTC include individuals in targeted areas of the Commonwealth who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) long-term care program as well as individuals who receive both Medicare and Medicaid. ¶

2. BACKGROUND

The DMAS is the single State agency in the Commonwealth of Virginia that administers the Medicaid and FAMIS Plus programs, which are under Title XIX of the Social Security Act. FAMIS Plus is Virginia Medicaid's designation for its covered children. DMAS also administers the Virginia State Children's Health Insurance Program (SCHIP), known as "Family Access to Medical Insurance Security (FAMIS)", under Title XXI of the Social Security Act for low-income people. These programs are financed by Federal and State funds and administered by the State according to Federal and State guidelines. These programs include coverage of medical services for eligible Medicaid/FAMIS Plus and FAMIS enrollees. See Attachment XXIII of this RFP for a summary of Medicaid/FAMIS Plus covered services. While FAMIS is not a part of this contract, it may be necessary for the Enrollment Broker of this contract and the Broker of the FAMIS CPU contract to interface on an as needed basis.

The Department provides Medicaid/FAMIS Plus coverage to individuals primarily through two delivery systems: managed care and fee-for-service. The Department oversees the development, implementation, and operation of the managed care and fee-for-service programs. The Department currently operates two Medicaid/FAMIS Plus managed care programs: MEDALLION, a primary care case management program (PCCM) delivered through DMAS; and, Medallion II, a program that delivers care through managed care organizations (MCOs) under contract with the Department. In certain areas of the State, the Department contracts with only one MCO. In one MCO areas, recipients have the choice of the MEDALLION PCCM or the Medallion II program. The mandatory managed care programs operate under a Centers for Medicare and Medicaid Services (CMS) 1915(b) Waiver and in accordance with the Code of Federal Regulations.

The MEDALLION program is a managed care, mandatory Primary Care Case Management (PCCM) program. This program is administered in its entirety by the Department. In MEDALLION, a recipient's health care is managed by a primary care provider (PCP). The PCP manages the recipient's health care and acts as a gatekeeper for specialty service referrals. There are some services that do not require a PCP referral. Examples of these services include but are not limited to emergency services, outpatient mental health services, substance abuse services, and community mental health rehabilitative services. In return the PCP is reimbursed $3 per recipient per month (PMPM). Providers are reimbursed on a fee-for-service basis for all covered services rendered.

There are some individuals who are excluded from participating in MEDALLION, even if they reside in a MEDALLION region. These individuals are covered under the fee-for-service program. Examples of MEDALLION excluded individuals include, but are not limited to, children in foster

care, individuals who reside in a state mental institution, individuals with Medicare coverage and individuals who are enrolled in home and community based waivers, and hospice.

The Medallion II program is a fully capitated, risk-based, mandatory Medicaid/FAMIS Plus managed care program. In most areas of the Commonwealth, qualified Medicaid/FAMIS Plus recipients choose between at least two contracted Managed Care Organizations (MCO). In areas where only one contracted MCO participates, recipients have the choice of the MEDALLION PCCM or the Medallion II program.

Under Medallion II, the contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the recipient. The MCOs accept full financial risk for each recipient's health care. This monthly payment includes all covered contract services. There are some individuals who are excluded from participating in Medallion II, even if they reside in a Medallion II region. These individuals are covered under the fee-for-service program. Examples of Medallion II excluded individuals include, but are not limited to, children in foster care, individuals who reside in a state mental institutions, and individuals who are enrolled in hospice. There are certain services that are "carved out" of the Medallion II contract and reimbursed through the Department's fee-for-service program. These services include, but are not limited to, community mental health rehabilitative services, certain substance abuse treatment services, environmental lead investigations, school health services, dental services, and nutritional supplements for children under age 21. The complete list of managed care excluded populations and carved-out services is provided in Attachments XI, XII, , XIV, and of this RFP.

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In addition, the Virginia Medicaid program also provides coverage for services not otherwise covered for the general Medicaid population through other types of CMS waiver programs. Each CMS Waiver has an established set of eligibility and financial criteria as well as a unique set of benefits available to qualifying individuals. Certain home and community based waivers (HCB) operate under a 1915(c) Waiver, and allow Medicaid to cover in home and community based support services, including, but not limited to, personal care, home modifications, assistive technology, and certain other supportive services for Medicaid individuals who are at risk for institutionalization. Some HCB waiver programs available to enrollees include the Elderly or Disabled with Consumer Direction (EDCD), Technology Assisted, Mental Retardation Waiver, etc. Information about these waiver programs is available on the DMAS Website at http://www.dmas.virginia.gov/ltc-home.htm.

Some waiver services are available either through a traditional agency or through "consumer direction." Agency-directed services are controlled by an agency that hires staff and assigns them to the individual who needs services. Consumer-directed services are controlled by the person with a disability or by someone acting on his or her behalf. The consumer recruits, hires, supervises, and fires (if need be) his or her own staff. The consumer is the employer of his or her staff and signs off on the timesheets for payment, which are then submitted to a fiscal agent for payment. A person using consumer-directed services will have a facilitator, a covered service under the Home and Community Based (HCB) waiver, for assistance in learning about consumer-directed services and for ongoing support.

Historically, individuals who were enrolled in a HCB Waiver were automatically disenrolled and/or were not eligible to participate in the Department's MCO program. Instead these individuals were

covered under the fee-for-service program. However, the Department implemented a change to the Medallion II program effective September 1, 2007, where MCO enrolled individuals who subsequently become enrolled in a HCB waiver (except for the Technology Assisted Waiver) remain enrolled in their assigned MCO for medical services and transportation to medical appointments. The individual's HCB services (including transportation to HCB services) are managed and paid for under the Department's fee-for-service program. MCO individuals who become enrolled in the Technology Assisted Waiver continue to be disenrolled from the MCO, and remain covered under the fee-for-service program for acute and waiver services. In the first year of operation, this program change has allowed approximately 700 individuals to remain with their assigned MCO, thus avoiding disruption to medical client/provider relationships and enabling better coordination between acute and long-term care services.

2.2 Managed Care Volume and Participation

As of October, 2008, 724,093 individuals were enrolled in the Medicaid program. Medicaid/FAMIS Plus individuals in the eligibility aid categories of Aged, Blind, Disabled (ABD), and Low Income Families with Children (LIFC), with a few exceptions, are required to enroll into a Medicaid/FAMIS Plus Managed Care program. Managed Care participation by program (MEDALLION and Medallion II) is reflected in the map shown as Attachment XVI of this RFP.

The following table identifies the MCOs currently contracted with the Department; the number of enrollees in each respective health plan (including MEDALLION); and the geographical areas served by health plan.

Health Plan Enrollment, as of October 2008**

Health Plan	Number of MCO Enrollees	Number of Cities/Localities
AMERIGROUP Community Care	20,398	11 (Northern Virginia)
Anthem (Peninsula, Priority and HealthKeepers)	144,800	81 (Central Virginia, Charlottesville, Halifax, Northern Virginia, Tidewater, and Winchester)
Optima Family Care	123,596	80 (Central Virginia, Charlottesville, Halifax, Lynchburg, Tidewater, and Winchester)
CareNet by Southern Health	17,258	34 (Central Virginia and Lynchburg)
Virginia Premier Health Plan	115,939	91 (Central VA, Charlottesville, Halifax, Southwest, Lynchburg, Northern Virginia, Tidewater, and Winchester)
MEDALLION	50,841	20 (Alleghany, Bath, Bland, Buchanan, Carroll, Craig, Dickenson, Grayson, Highland, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, Bristol, Covington, Galax and Norton)
TOTAL	421,991	

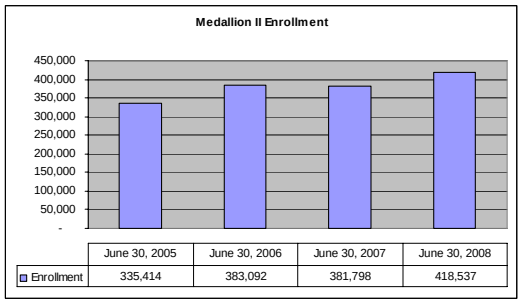
**October 2008 Managed Care Enrollment Report

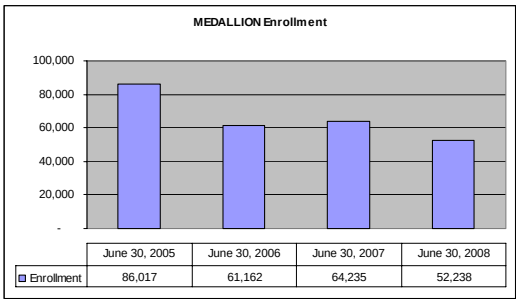
2.3 Managed Care Expansion History

Deleted: <#>**Virginia Acute and Long-Term Care (VALTC) Integration** ¶
Virginia Acute and Long-Term Care Integration (VALTC) is an initiative designed to improve the quality of life of Virginia's Medicaid-enrolled seniors and individuals with disabilities. This new managed care system strives to empower qualifying individuals to remain independent and reside in the setting of their choice for as long as possible through the provision of a streamlined primary, acute, and long-term care service delivery system. VALTC offers ongoing access to quality health and long-term care services, care coordination, and referrals to appropriate community resources. Information about the Integration of Long Term Care, including the pilot locality is available on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm.¶
¶
Currently, individuals who are dually eligible for Medicare and Medicaid, as well as the fee-for-service individuals who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver and are excluded from participating in managed care. (As described in Section 2 above, MCO enrolled individuals, who subsequently become enrolled in the EDCD waiver, maintain their MCO enrollment for acute care benefits and receive their waiver benefits through the Department's fee-for-service program.) These individuals, who are often very frail, currently receive very little assistance with the coordination of their services – and their services are often very complex.¶
¶
Through VALTC, adult individuals 21 and over who are dually eligible (have Medicaid and Medicare coverage) and/or who are EDCD waiver participants (in certain areas of the Commonwealth) will be able to receive their health care and long-term care services through a coordinated delivery system. (Initially children under age 21 will not be covered under the VALTC program.) The ... [6]

Deleted: In addition to the enrollment above, participants in the VALTC program will include dual eligible and EDCD waiver enrollees who reside in the pilot catchment area as reflected in Attachment XXII. The VALTC MCO program will include participation by MCOs, contracted with the Department in response to the VALTC MCO Contract. In addition to acute care services, VALTC MCOs will be responsible for long-term care services as reflected in Attachment XXII. The VALTC expected volume of participation was described in Section 2.1 above. ¶

The fee-for-service and managed care delivery systems are structured to manage the growing Medicaid enrollee population. The following tables illustrate an increase in enrollees for the Medallion II program in the past four fiscal years (FYs). The Medallion II program continued to increase in FY 2008 given the October 1, 2007 Lynchburg expansion adding approximately 14,000 enrollees. Due to an increase in the Medallion II program, there has been a corresponding decrease in the MEDALLION program.





Medallion II Geographical Expansions

Region	Effective Date	Number of Recipients
Northern Virginia	9/1/05	29,000
Buckingham/Nelson/Fluvana	11/1/05	2,700
Winchester/Culpeper	12/1/05	8,600
Danville/Pittsylvania/Charlotte/Halifax	5/1/06	23,000
Lynchburg	10/1/07	14,000

2.4 Enrollment Process

The Department and the selected Enrollment Broker Contractor (as a result of this RFP), will be responsible for conducting all enrollment activities for Medicaid/FAMIS Plus managed care eligible recipients, including those participating in MEDALLION, Medallion II, and VALTC. The selected Enrollment Broker will facilitate enrollment and education services for the required populations and programs as the programs expand, as the population changes, and/or geographical area changes. Enrollment processes are more fully described in Section 3 of this RFP.

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2.5 Enrollment Mailings

Enrollment mailings are sent by the Department, through its contracted mailing vendor, and include pre-assignment, re-enrollment, and open enrollment mailings. Pre-assignment packages will vary depending on the recipient's program (MEDALLION, Medallion II, and VALTC) and area of residence. All pre-assignment packages will include a selection letter. The enclosures will vary depending on the program and area of residence, but may include MCO Comparison Chart, MCO or PCP brochure, list

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of available MEDALLION PCPs, MEDALLION Help Sheet, Annual Notice of Health Care Rights. (Current documents can be viewed at www.virginiamanagedcare.com/http.)

2.6 Role of Enrollment Broker

The Department contracts with an Enrollment Broker to assist Medicaid/FAMIS Plus managed care eligibles in selecting and enrolling into a managed care plan of their choice. The Enrollment Broker has multiple functions and responsibilities including but not limited to:

- Providing information to recipients to assist them in choosing a health plan. This includes providing basic education on managed care and preventive health care.
- Operation of a comprehensive toll-free telephone call center capable of responding to enrollee concerns; providing recipient education; and handling enrollment activities.
- Dedicated tracking and reporting system for MEDALLION, Medallion II, This can be achieved through either separate telephone lines or through an internal system that tracks the program of the individual.
- Providing specific information about each health plan such as the plan's network of providers including physicians, hospitals, etc.
- Tracking complaints and inquiries from recipients, including MEDALLION, Medallion II, program enrollment. The Enrollment Broker is responsible for resolving complaints and inquiries or forwarding them to the appropriate entity for resolution. Resolution is the responsibility of the Contractor. For clinical complaints of an urgent nature, or complaints the Enrollment Broker is not able to resolve, the Contractor shall refer the complaint immediately to the Department.
- Handling all enrollment related activities.
- Interface with the Virginia Medicaid Management Information System (VAMMIS) per requirements described in this RFP.
- Administering the Health Status Assessment (HSA) tool for Medallion II enrollees upon new enrollment, and/or when changes are made to enrollment, to determine the health status of the recipient, any on-going treatments, pre-authorized services, or authorized durable medical equipment currently utilized by the recipient, which would necessitate coordination of care on the part of the MCO.
- Triaging recipient calls to participating MCO member services departments, local DSS agencies, or the Department's Recipient and Provider Help Lines, or the Department's managed care staff.
- Development and maintenance of member materials including regional comparison charts for MCO programs as described in Section 3 of this RFP.

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- Reporting call center statistics on performance and other areas as described in Sections 3 and 4 of this RFP.

- Developing and implementing activities toward continuous quality improvement of customer service and enrollment functions.

- Development and maintenance of an informational website as described in Section 3.32 of this RFP.

- Providing the full scope of services described in Sections 3 and 4 of this RFP including for expansion of covered groups and/or geographic expansions.

3. REQUIREMENTS AND TECHNICAL PROPOSAL

This section contains the contractual requirements and functional description for education and enrollment in managed care plans. At a minimum, the following components must be addressed. The following methodology suggests a protocol and structure for the education and enrollment process. However, the Department may consider alternative approaches for achieving the requirements described.

3.1 Overview and Regulatory Requirements

The primary purpose of the Enrollment Broker is to assure that the target population receives timely and adequate information and education about the Managed Care programs, and to perform all functions directly related to the enrollment of the recipients with the health plan of their choice. In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 438, part 810, Enrollment Broker activities shall be delivered by an external entity with no corporate connections or financial interest in any of the Virginia contracted MCOs. These requirements are further detailed in Attachment XXV of this RFP. As part of its technical proposal, the Offeror shall provide a statement attesting to their freedom from conflict of interest, as well as full compliance with enrollment broker related activities, in accordance with Federal Regulations and as detailed in Attachment XXV of this RFP.

The Enrollment Broker will enter provider assignments for the recipients' MCO or PCP enrollment directly into the VAMMIS, according to guidelines set forth by the Department. The Enrollment Broker is responsible for collecting, maintaining, analyzing, and disseminating enrollment and disenrollment data.

The Enrollment Broker shall ensure that the ongoing managed care enrollment process for Medicaid/FAMIS Plus recipients is consistent, effective, and service oriented, continually pursuing opportunities for improvement. The Department and the Enrollment Broker shall monitor MCO enrollment for Enrollment Broker objectivity by auditing of telephone calls and review of monthly plan change reports.

Enrollment options should include enrollment requests through a variety of methods including, but not limited to, telephone HelpLine toll-free number. The Offeror's proposal must describe in detail various options it will make available for the enrollment process, including but not limited to technology, staffing and any planned innovative processes. Additionally, the Offeror's proposal must include a detailed implementation plan. The implementation plan must demonstrate the Enrollment Broker's proposed schedule to implement full operations within 30 days of contract award to successfully manage the requirements described in sections 3 and 4 of this RFP.

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3.2 Populations Covered

The Enrollment Broker is responsible for the full scope of enrollment related activities for the Medicaid and FAMIS Plus populations, as described in Sections 3 and 4 of this RFP for the MEDALLION, Medallion II, programs.

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The Offeror's technical proposal shall describe how it will distinguish each program/population, for monitoring and reporting purposes.

Deleted: The Offeror shall include in its cost proposal separate pricing for the VALTC population as reflected in Attachment III b.

3.3 HelpLine Operations

The Enrollment Broker must operate an office in the Richmond metropolitan area for ease and efficiency to fulfill the requirements of the contract. The call center is not required to be in the State of Virginia. The Contractor must provide the capacity for the Department to monitor calls remotely and timely at no cost to the Department. The Offeror's proposal must include a description of method that it will provide to enable the DMAS EB Contract Monitor to perform routine monitoring of CSR calls for all populations covered under the contract resulting from RFP 2009-02. The Enrollment Broker must provide an appropriate work space for the Department's Contract Monitor as well as the necessary telephone, etc., technology for monitoring call center activities. The Enrollment Broker must supply and furnish its office at its own expense, to include telephones, fax, paper supplies, personal computers, etc.

The Enrollment Broker shall provide and maintain a toll free telephonic Managed Care HelpLine. In addition, the Enrollment Broker shall assure that the phone is transitioned seamlessly and correctly in-house regardless of the phone number (if using separate phone numbers) or prompt entered by the recipient. The Helpline's responsibilities will be to educate recipients regarding managed care and enroll recipients into the MCO or PCP of choice for each program (MEDALLION, Medallion II,). The Enrollment Broker, with Department approval, shall develop criteria for call handling, and produce a written manual of policies and procedures with separate sections for Medallion II, MEDALLION, and specific scripts and responses for staff training and operations. Enrollment Broker staff must be informed of any program changes on an on-going basis.

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The HelpLine will be staffed a minimum of 9 1/2 hours a day, 8:30 AM - 6 PM, Monday through Friday. The Department may request the Enrollment Broker work weekend hours under special circumstances with at least one-week notice. The Enrollment Broker may be closed for twelve (12) recognized State holidays. The Enrollment Broker may be allowed other days off at the discretion of the Department on an annual basis.

3.4 Staffing Requirements

The Enrollment Broker must provide the Department with an organizational chart with its submitted proposal and as changes occur following contract award, depicting each functional unit of the organization, number and type of staff for each function identified and lines of authority governing the staff. The names of key personnel (i.e., Regional Manager, local Project Director, Call Center Supervisor – if different than the local Project Director, Systems Administrator, and Quality Assurance Director/Trainer) must be shown on the organizational chart. The minimum required staffing levels are as follows:1 Regional Director (Project Manager), 1 Systems Administrator, 1 Quality Assurance/Trainer, 1 Administrative Assistant/HR Specialist, 1 Call Center Supervisor, and a sufficient number of Customer Service Representatives (full and part time), to handle enrollment related activities for all populations as described in this RFP.

The Enrollment Broker *is not required* to have dedicated staff by program, and may cross-train staff on all programs.

Deleted: The Department anticipates that the VALTC program will require a maximum of two full-time staff to manage the program.

Under the existing Enrollment Broker Contract, staffing levels are reflected in the table below:

Quantity	Staff Position
1	Project Manager
1	System Administrator
1	Training Manager – Spanish Speaking
1	HR Manager
2	Call Center Supervisors – 1 Spanish Speaking
1	Quality Assurance Analyst
11	Customer Service Representatives (3 Spanish Speaking). 8 FTEs
Up to 10 CSRs	Overflow Team (used on an as-needed basis)

If any member of the project management team, as identified in the Contract, becomes unavailable for any reason, the Enrollment Broker shall submit to the Department the resume of the proposed replacements, and offer the Department the opportunity to review the qualifications of the proposed applicant. If the replacement applicant is not acceptable to the Department, the Department reserves the right to require the Enrollment Broker to select another applicant. Failure to maintain the required staffing level to meet contract requirements may result in a reduction in the Department's reimbursement to the Enrollment Broker. The Department must agree to staffing levels. In addition, reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Enrollment Broker. The Enrollment Broker shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

3.4.1 Customer Service Representatives (CSRs)

The Enrollment Broker shall screen, train and supervise sufficient customer service staff to maintain on-site and HelpLine access, during normal and peak times, according to Department criteria. The Enrollment Broker should select the type of representative whom the Enrollment Broker and the Department feel would best serve enrollee populations covered under this RFP,

including specially trained staff to handle the unique needs of the elderly and disabled populations in the MEDALLION, Medallion II programs.

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Generally, the Enrollment Broker must seek high quality service staff with the following capabilities:

- Enthusiasm about the role they will play in providing counseling, education and customer service to the Medicaid/FAMIS Plus population and/or representatives;
- Good interpersonal and communication skills, including extensive telephone skills;
- Ability to quickly learn the accurate factual information that will be conveyed, and a readiness to use research materials;
- Appreciation for the importance of confidentiality and HIPPA guidelines in prescreening calls
- Ability to use multiple computer systems to access and input data; and
- Good sense of the Virginia Medicaid recipient community they will be serving;
- Ability to work with special needs populations.

In addition the Enrollment Broker shall recruit, hire and train customer service staff who shall, at a minimum:

- Produce a system of call content documentation, using automated record keeping;
- Ensure that personnel responding to inquiries are knowledgeable about Virginia Medicaid programs, standards and protocols;
- Provide a highly effective and responsive operation in handling complaints/grievances;
- Provide professional, prompt and courteous services to recipients and view customer services as a high priority. Greet all callers and identify themselves by name. Treat all recipients with dignity and respect and ensure each recipient's right to privacy and confidentiality;
- Promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds;
- Provide access to a native speaking representative or to telephone based translation services. The Enrollment Broker shall ensure that enrollee language needs are addressed. This applies to all non-English speaking enrollees and is not limited to prevalent languages;
- Establish and maintain effective working relationship and communication with the Department, MCOs, Health Care Providers, Local Department of Social Services, and Managed Care Recipients;
- Conduct interviews to acquire and verify information and efficiently communicate with recipients including those with special health care and communication needs such as hearing/speech impairments, interpreter services, etc.;
- Assist recipients in selecting a MCO, PCP or other providers in an efficient, and unbiased manner; giving specific information such as whether or not PCPs are accepting new recipients, available PCP sites, the MCO's network of providers including physicians, hospitals, home health agencies, personal care providers, etc.;

- Inform recipients of the circumstances in which recipients are excluded from the mandatory managed care participation;
- Explain adequately and appropriately the managed care eligibility guidelines and respond to managed care related inquiries;
- Possess knowledge of managed care covered and non-covered services and how to access these services through the managed care programs or other sources;
- Exercise sound judgment and act responsibly and professionally in stressful or unpleasant situations;
- Assist recipients eligible for managed care in the resolution of problems relating to the accessibility of health care delivery, including but not limited to, identifying provider issues, language barriers and special needs or disability accessibility issues;
- Inform new recipients with children under 21 of the importance of well child care, including immunizations and services available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program;
- Provide information on how and when to access the MCO's and the Department's recipient services or grievance/appeals departments;
- Help recipients maintain continuity of care through existing recipient/provider relationships by assisting them with provider access issues; answering questions regarding MCO provider network participation; and explaining how specialized services should be accessed through managed care programs;
- Respond to provider questions concerning recipient assignment and refer provider eligibility questions to the appropriate MCO or fee-for-service provider helplines;
- Be alert to possible discrepancies between the MCO's approved materials and methods and anecdotal information provided by recipients. Any discrepancies discovered should be documented and forwarded to the Department.

Deleted: <#>Perform outbound calls per Department guidelines to assist newly eligible VALTC EDCD enrollees with plan choices;¶

3.5 Training of Staff

The Enrollment Broker shall develop and maintain a training program for new employees. Training modules must include all populations served (MEDALLION, Medallion II). Training must emphasize the importance of objectivity towards all health plans and individual choice. Representatives will not be allowed to recommend one health plan over another. Training shall also emphasize that all callers be treated with dignity and respect, and be sensitive to the caller's need for privacy. Such a program shall:

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- Provide new staff with the knowledge, skills and system capabilities they require to be effective and responsive workers.
- Be written, and comprised of three components: educational objectives, training modules, which includes at a minimum a Customer Service training module for all populations and a schedule that details each training element.
- Enable the staff to understand or effectively act on the following:
    1. Key health care issues and the health care system.
    2. The mission, goals, and structure of Virginia's managed care programs (MEDALLION, Medallion II).
    3. The Medicaid/FAMIS Plus recipient population, including eligibility guidelines for the managed care programs.

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4. EPSDT program and services.
5. Recipient health care needs.
6. Recipient confidentiality.
7. The use of the dedicated computer system and systems operations.
8. VAMMIS training for enrollment entries.
9. Local and central office structure and practices.
10. Proper procedures to document and forward complaints and appeals
11. Successfully enroll recipients, including MEDALLION, Medallion II, , in the health plan of their choice.

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The Offeror's proposal must describe in detail the proposed staffing plans, training plans, policies and procedures, etc.

3.6 Call Center Performance Standards

Present Call Volume for MEDALLION and Medallion II population: The reported Fiscal Year 2008 total call volume was 156,317 calls, including MEDALLION, Medallion II, and public calls (general). The average monthly call volume is approximately 15,000. For more information on present call volume, see Attachments IV, V and VI of this RFP.

Deleted: Anticipated Call Volume for the VALTC population: The Department estimates call volume for the VALTC population to average around 750 calls per month, based on an annual total of 9,000 (including in-coming and out-going calls), with the higher call volume occurring during the initial start-up and during annual open enrollment. ¶

The Enrollment Broker must ensure that the HelpLine meets (and provides necessary reports for) the required performance standards of promptness and quality as follows:

- The HelpLine must be staffed to answer at least 95% of all incoming calls in three rings or less (an automated voice response system which places call in queue may be used at initial time of call);
- No more than 3 calls per operator should be in the queue at any time;
- Telephone calls shall be of sufficient length (average 4-5 minutes) to assure adequate information is imparted to the recipient;
- The average wait time in the queue should not be longer than 3 minutes (180 seconds) for 90% of incoming calls answered each month;
- The rate of abandoned calls can not exceed 10% in any one week;
- The average wait time to abandon should not be longer than 3 minutes for 95% of incoming calls;
- All call line inquiries that require a callback shall be returned in one business day of receipt one hundred percent (100%) of the time;
- Only calls that meet the criteria specified by the Department should be referred to the Department, i.e. billing/claims issues, complex coverage, urgent clinical or complaint issues, and MEDALLION provider issues;
- The Enrollment Broker must develop a system to continually audit telephone responses for customer service skills as well as accuracy of responses. The Enrollment Broker must provide an example of staff audit progress reports used internally, for review by the Department. Deficiencies must be addressed immediately. The Department shall audit the HelpLine for monitoring and quality improvement purposes at any time, including on-site or remote monitoring;

Deleted: (VALTC calls may require longer than average timeframes to fully address the caller's concerns)

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- Performance standards as noted above must be met in consideration of all populations served, lengthy calls, and additional customer service requirements as specified by the Department; and,
- Provide call center reports per requirements described in Section 4.

3.7 Telecommunications System

The Enrollment Broker shall install, operate, monitor and support an automated call distributor system, sufficient to handle each required program. The Offeror must provide as part of its proposal a description of the technological capabilities it will use to meet these required capabilities.

The Enrollment Brokers telecommunication system shall have the capability to accept local and toll-free calls, make outbound calls, and all of the following requirements:

- Have the capacity to handle all telephone calls at all times during the hours of operation; have the upgrade ability to handle any additional call volume. Have adequate staffing and equipment during high peak times such as open enrollment, new program implementations, expansions, etc. Any additional cost for staff, equipment, or other needs, shall be the responsibility of the Enrollment Broker unless otherwise stated in this RFP.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff, i.e. bilingual, in an efficient manner.
- Have systems capacity to handle large percentage of calls during the first two weeks of the month which coincides with mailings.
- Manage outbound call volume.
- Provide detailed analysis of the calls received, including quantity, time it takes to answer calls initially (by ACD system), length of time it takes the caller to reach a live person, and length of call.
- Measure the number of callers encountering busy signals, line access, or hanging up while on hold.
- Provide greeting message when necessary and educational messages approved by the Department while callers are on hold.
- Ensure TDD/TDY capabilities.
- Refer calls to the Department's Provider and Medicaid/FAMIS Plus Recipient HelpLines when appropriate.
- Ensure the installation and maintenance of its telephone system in a way that allows calls to be monitored by a third party for the purposes of evaluating Enrollment Broker performance with a message which informs callers that such monitoring may occur. Call monitoring by a third party, for accuracy and quality of information, must be available at the location of the Enrollment Broker, as well as remotely.
- Ensure that there is a back-up telephone system in place that shall operate in the event of line trouble or other problems so that access to the HelpLine by telephone is not disrupted.
- Ensure that telephone translation services are accessible via the toll-free number and that recipients will be involved in three way conversation with the language line and not have to make an additional call.
- Report and assesses the busiest day by number of calls.
- Measure the number of calls in the queue at peak times.

- Provide detailed daily reports of abandonment rate, average wait time to abandon, and abandonment during call transfer.
- Provide real-time information on call center performance, e.g., outgoing calls, calls waiting, agents logged-in, available agents, etc.
- Ensure call tracking reporting by program.
- Ensure reporting of complaints and grievances by program (MEDALLION, Medallion II,).
- Report types of calls by program (either through the ACD system or via the Enrollment Broker's internal tracking system.)

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The Enrollment Broker agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department shall take title to these telephone numbers. Any amount owing on these numbers shall be the sole obligation of the Enrollment Broker.

3.8 Processing Enrollment Requests

The Enrollment Broker shall process all enrollment requests on the same day the request is received. An effort must be made to process enrollments by the VAMMIS cut-off date (18th day of each month) to avoid an unnecessary assignment or month's postponement of the managed care enrollment.

Deleted: (There are unique requirements, as described in Section 3.10, for Enrollment Broker entry of VALTC enrollments for newly eligible EDCD waiver enrollees.)

Enrollment requests received by mail from recipients that cannot be processed due to incomplete information must be returned to the recipient the same day received with the missing information highlighted. Where possible, the recipient shall be telephoned on the same business day or the next day, so the missing information can be obtained immediately. Once the missing information is obtained, the enrollment form shall be processed within the same guidelines set above.

The Enrollment Broker must provide the enrollment staff with the current regional and programmatic comparison charts and other relevant materials developed by Enrollment Broker and the Department to assist the recipient in selecting the most appropriate health plan. At a minimum, information to be considered in the decision includes: location of the PCP or other provider, contracting hospitals, specialist network, and standard and special health care services offered by each health plan. In processing enrollment requests, the Enrollment Broker shall:

Deleted: For VALTC, long-term care provider networks shall be considered in the decision.¶

- Ensure callbacks within one (1) business day for questions involving further research;
- Establish procedures subject to Department approval, to determine when Department intervention should be sought and how it should be obtained to adequately resolve or respond to recipient or provider issues;
- Ensure representatives have received extensive customer service telephone training and Virginia Medicaid specific training to include MEDALLION, Medallion II, program instruction;
- Maintain a plan for "triaging" recipient calls, which are determined to be outside the scope of the HelpLine's expertise, to the MCO's recipient service representatives, MEDALLION PCP, the correct local social service agency for Medicaid eligibility questions, the Department's Recipient or Provider HelpLine or to the Department's managed care staff;
- Capture and refer exemption and good cause requests using a format/process agreed upon by the Department and the Enrollment Broker;

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- Coordinate with the appropriate Department's staff regarding recipient and provider enrollment issues and continuity of care;
- Identify and report to the Department recipients with other benefit coverage such as Group Health Insurance or change of access, etc.;
- Process daily panel requests from providers within one business day;

Deleted: <#>Conduct outbound calls assisting newly enrolled VALTC (EDCD) enrollees with plan choices within one business day upon receipt of necessary information from the Department;¶
<#>Enter VALTC MCO enrollments for newly enrolled EDCD enrollees into VAMMIS within no more than 3 business days 100% of the time.¶

3.9 MEDALLION and Medallion II Managed Care Enrollment

Managed Care eligibles will be pre-assigned to a MEDALLION PCP or a MCO by the Department. For newly eligible recipients, this occurs 15-45 days after eligibility is entered into VAMMIS. Clients are preassigned to a MCO for Medallion II or an enrolled PCP for MEDALLION. Preassignment is based upon client history, family history, or is random via system algorithm. As part of the preassignment process, recipients receive "pre-assignment" letters indicating the choices available in their locality. (Preassignment letters are sent by the Department's mailing contractor). These letters will indicate a pre-assigned PCP or MCO in which the recipient will be enrolled if he/she does not make a selection through the Enrollment Broker. The letter also designates the time frame in which recipients have to call the Enrollment Broker to confirm or change their selection. Recipients who do not call to confirm or make a selection are enrolled with the preassigned MCO for Medallion II or PCP for MEDALLION.

MCO/PCP enrollees have 90 days after the effective date to change MCOs/PCPs for any reason. It is important to note, however, that approximately 80% of all individuals accept the assignment made by the Department and do not call to change their health plan. Changes requested and entered into VAMMIS before the 18th of the month will be effective the 1st day of the following month; after the 18th of month, enrollment is delayed another month. Recipients may elect to change to another MCO/PCP, where there was no prior assignment to that MCO/PCP, and receive another 90 day trial period.

If a MCO/PCP enrollee loses Medicaid eligibility, the MCO/PCP enrollment also ends. If the enrollee re-gains Medicaid eligibility within 60 days they are automatically re-enrolled with the previous MCO/PCP on the first day of the next available month.

MCOs are notified of the recipients assigned to their health plan by the Department around the 20th of each month. The MCO sends their newly enrolled members a MCO packet, including a MCO identification card, member handbook, and Medallion II MCO provider directory. The member should receive this information by the last day of the month prior to the MCO effective begin date.

The Enrollment Broker staff shall be educated on the Department's preassignment and disenrollment processes; shall respond to enrollees with questions about these processes, and shall handle processing of all enrollment requests received as a result of these processes as described in Section 3.8 above.

The following table provides an approximate timeline from preassignment to enrollment for individuals.

Deleted: except for those individuals who are newly enrolled to the EDCD Waiver and who will be enrolled into a VALTC MCO, as described in Section 3.10 below

Timeline	Activity
Day 1	Medicaid/FAMIS Plus Eligible

Day 4	Recipient receives fee-for-service Medicaid card
Day 18	System preassigns to MCO or PCP
Day 23	Recipient preassignment packet is mailed
Day 45	Recipient assigned to MCO or PCP
Prior to the first day of the month of MCO enrollment	MCO member information including ID card is mailed and received

3.11 Open Enrollment

A twelve-month managed care enrollment period is part of the MEDALLION, Medallion II programs. The Department has regional annual open enrollment periods designated by the area of the state where the recipients live. Each enrolled individual receives sixty days notice by mail prior to new effective date to change MCOs or PCPs. The Enrollment Broker is responsible for complying with the guidelines established for changing MCOs/PCPs and must have appropriate systems in place to ensure health plan changes are made within the appropriate allowable time frames. The Enrollment Broker must ensure that Representatives are educated about the twelve-month enrollment period.

There are five six (5) open enrollment periods for Managed Care recipients as follows:

MEDALLION	February 1
Central Virginia	April 1
Tidewater	July 1
Northern/Winchester	September 1
Southwest/Western	November 1

3.12 Exclusion from Managed Care Enrollment

Recipients eligible for managed care enrollment who are in pre-assignment may request exclusion from managed care (MEDALLION, Medallion II,). Managed care exclusions will be handled by the Department in accordance with the Department's criteria. The Enrollment Broker must submit requests and accompanying documentation to the Department for processing. At minimum, this information includes the recipient name, Medicaid ID#, caller/requester name, phone number, and the reason for the exclusion request. There is a designated form to capture this information. The form can be sent by the EB to DMAS via secure email or by fax. The Department will send a response to the exclusion request to the recipient. Managed care exclusions are provided for each program (MEDALLION, Medallion II,) as Attachments XI, XII, of this RFP.

3.13 Disenrollments, Re-enrollments and Plan Changes

The Enrollment Broker shall be responsible for the disenrollment and re-enrollment of mandatory managed care recipients from one MCO or PCP to another, according to guidelines set forth by the Department for each population (MEDALLION, Medallion II,). The Enrollment Broker shall develop a system to assign reason codes for disenrollments, in accordance with Department standards. The

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Preassignment for VALTC participants, except those who are newly enrolled into the EDCD Waiver, will follow the process described above for Medallion II, and shall be processed by the Enrollment Broker according to the requirements described in Section 3.8. The Department's mailing contractor will send VALTC recipients a preassignment letter, MCO brochure, and VALTC MCO comparison chart indicating the MCO choices available within their locality. VALTC recipients will have the option of changing their preassigned MCO by contacting the Enrollment Broker prior to the effective date of their MCO enrollment. Recipients are also allowed to change MCOs within 90 days of effective date of enrollment into a MCO. Recipients may decide to change to another MCO (where there was no prior assignment to that MCO) and receive another 90 day trial period. ¶

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Similar to Medallion II, MCOs are notified of the recipients assigned to their health plan by the Department around the 20th of each month. The MCO sends their newly enrolled members a VALTC MCO packet, including a VALTC MCO identification card, VALTC member handbook, and a VALTC MCO provider directory. The member should receive this information by the last day of the month. ¶

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The initial enrollment process for individuals who are ***new to the EDCD Waiver AND who reside in the VALTC pilot area*** shall be handled by the Enrollment Broker through an expedited telephonic enrollment process, including out-bound telephone calls. The volume of newly enrolled EDCD waiver recipients eligible to participate in the VALTC program is anticipated to be between 60-80 per month. This expedited telephonic enrollment process is necessary as VALTC individuals are often frail and in urgent need of services. Events that occur prior to the Enrollment Broker's notification of these individuals is as follows. Individuals are screened for the EDCD Waiver by a Depart ... [7]

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Enrollment Broker must be able to modify the reason codes to meet the Department's specifications. The Enrollment Broker shall provide the Department an updated list of reason codes as modifications are made. In instances of disenrollment and plan changes, the Enrollment Broker shall make a bona fide effort to determine the reason for disenrollment or plan change that must be clearly documented in the Enrollment Broker's system for future reference in determining and addressing quality issues and for reporting purposes. The health plan change report shall be delivered to the Department monthly. Where there appear to be options to disenrollment or plan changes the Representatives must inform the recipient of these options to enable the recipient to make a more informed decision. See Attachment XXIX for further information on annual enrollment activity.

3.14 Enrollment Transfers

The Department may expand or terminate a health plan or a PCP agreement for MEDALLION, Medallion II, populations. In these cases, the Department will handle enrollment transfers systematically via the automated preassignment process as previously described. The Enrollment Broker shall handle calls from recipients that transfer to a different participating MCO or PCP provider within existing program rules as described in 3.13 above.

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3.15 Enrollment Materials

The Enrollment Broker is responsible for designing, printing and maintaining adequate stock of comparison charts and MCO brochures for the Medallion II MCO programs. Additionally, the Enrollment Broker is responsible for designing, printing and maintaining adequate stock of PCP brochures for the MEDALLION program. Copies of current comparison charts and MCO and PCP brochures are available on the DMAS website at http://www.dmas.virginia.gov/mc-enrollment.htm . For contract year 2007-2008, the current enrollment broker ordered 580,800 material items which include comparison charts, PCP, and MCO brochures. See Attachment XXIV for additional details.

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A fulfillment packet is defined as enrollment material as requested by the enrollee. This could contain MCO comparison charts, PCP or MCO brochure, PCP provider listings, or a combination there-of. Fulfillment packets shall be mailed by the Enrollment Broker upon request of a recipient within two (2) business days. For Contract year 2007-2008, the current enrollment broker mailed 188 comparison charts, 978 PCP brochures, and 102 MCO brochures, as part of 1,282 fulfillment packets. The Enrollment Broker is responsible for all postage costs associated with mailing fulfillment packets. See Attachment XXIV for additional details.

The Enrollment Broker shall develop, modify, print and distribute materials including but not limited to enrollment materials pursuant to guidelines set forth by the Department. Materials shall be revised annually or when a plan is added or deleted from a locality. Materials shall be provided in English and Spanish as a minimum requirement.

All materials must be in an easily understandable and culturally sensitive printed or audio-visual format. The Department must approve all materials while they are in draft form and may recommend changes in whole or part. The Department should be consulted on all approaches to document development before the final approach is decided upon. The Enrollment Broker shall use the same

forms and formats among all of its sites, and maintain standardization throughout materials to the extent feasible. The Department may modify materials at any time.

After final approval, the Enrollment Broker shall be responsible for printing all written materials; maintaining a sufficient stock of materials on site; and distributing materials as needed at the Enrollment Broker's expense. As materials are revised, the Enrollment Broker shall provide updated files to the Department's mailing contractor. The Enrollment Broker shall also provide a sufficient stock of materials for the Department's Managed Care Unit of the Health Care Services Division. In addition, the Enrollment Broker shall supply upon request an inventory of comparison charts to the Department's contracted MCOs. The Enrollment Broker shall notify the mailing contractor to provide a supply of materials at the verbal request of the Department on an as needed basis.

The Offeror must submit sample materials reflective of the Offeror's proposed technology and abilities; and in following with the requirements described in this RFP; as part of its submission proposal.

At a minimum, the Enrollment Broker shall develop materials that:

- Contain a "worksheet" or checklist on how to select an MCO.
- Explain the difference between fee-for-service and managed care (MEDALLION, Medallion II,); explain the importance of a "medical home" and coordinated health care.
- Develop comparison charts for Medallion II, customized to the specific and intended audience.
- Describe services covered through the managed care programs, including EPSDT services, with emphasis on preventive health care for adults and children.
- Encourage recipients to maintain appropriate existing provider relationships, or to otherwise make their own choice of a PCP.
- Inform recipients of their right to transfer from one PCP to another, and the procedures for doing so.
- Inform recipients that primary care services may be obtained only from the recipient's PCP.
- Inform recipients that most specialized care may be obtained only by referral from the recipient's PCP.
- Compare MCO plans and programs via a comparison chart; it is the responsibility of the Enrollment Broker to update the chart once per year prior to open enrollment.
- Update comparison charts with new health plan information, as needed, other than the required annual revisions, at the expense of the requesting health plan.
- Educate recipients regarding services that may be furnished without referral from the PCP, such as family planning, and ways to access such services.
- Educate recipients regarding the proper use of the emergency room.
- Inform recipients about how they may access mental health and substance abuse services and other special health care service needs.
- Inform recipients of the managed care appeal and grievance process.
- Inform recipients about Medicaid-authorized transportation services.
- Inform recipients about the Managed Care website.

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3.16 Language and Disability Requirements

The Enrollment Broker shall provide access to a native speaking representative or to telephone based translation services. The Enrollment Broker shall ensure that enrollee language needs are addressed. This applies to all non-English speaking enrollees and is not limited to prevalent languages. The enrollee cannot be charged a fee for translator or interpreter services. The Virginia Relay Service (TDD/TYY) for the deaf and hard-of-hearing must be available to the enrollee and used by the Enrollment Broker when appropriate.

Printed material should be oriented to the target population, and understandable at the 12th grade level. The Enrollment Broker must provide for translation of printed materials into Spanish. The materials may also be produced and distributed in other media formats as deemed most effective by the Enrollment Broker and the Department to accomplish specific objectives within the education and enrollment functions as described in this RFP. The content and volume of all materials, whether printed or distributed via other formats, must address the informational needs of those recipients who speak languages other than English or Spanish, those with visual or hearing impairments, or those whose literacy level renders printed material less than effective.

The Enrollment Broker's informational materials must indicate the ability to provide translation services as dictated by the targeted populations. The Enrollment Broker must ensure that the special communication needs of all aged or disabled recipients are addressed including access to a TDD/TYY, according to Commonwealth of Virginia State regulations.

3.17 Health Status Survey Questionnaire

The Health Status Assessment and Survey Questionnaire (HSA) is a list of health related questions designed to establish the recipient's basic health status and assist the Medallion II MCO in the identification of areas of concern and resource referrals. It is mandatory that the Enrollment Broker complete an HSA for all Medallion II program recipients. The HSA must be completed upon contact with newly enrolled recipients or when a recipient calls to change from one Health Plan (MCO) to another. It is also designed to establish the impact of managed care on the overall health status of the managed care population. A sample HSA is provided as Attachment VIII and HSA monthly volume is provided as Attachment VII in this RFP.

The HSA Survey development and administration requirements are as follows:

- The Enrollment Broker shall work with the Department to develop and modify the HSA survey tool. In addition to determining the health status of the recipient, the tool must specify any on-going treatments, pre-authorized services, or authorized durable medical equipment currently utilized by the recipient, which would necessitate coordination of care on the part of the MCO. The survey tool will also assist the MCOs in arranging and continuing care for recipients with special health care needs.
- The Enrollment Broker shall administer the HSA tool and maintain the original or electronic copies of the original, for audit purposes.
- The Enrollment Broker shall administer the HSA as age appropriate in a manner sensitive and responsive to each recipient's circumstances.

- The Enrollment Broker shall review the HSA results with the recipient to enable the recipient to make an informed choice regarding a MCO to best meet his/her needs.
- After final enrollment, for Medallion II enrollees, the Enrollment Broker shall forward a copy of the HSA to the recipient's MCO, in a format and timeline agreed upon by the Enrollment Broker MCO and the Department; i.e. electronic bulletin board.
- The Representative must inform recipients who have an on-going medical condition of the need to contact the MCO to arrange for coordination of care.
- The Enrollment Broker shall work with the Department to review and update the HSA tool, as needed.

3.20 Policies and Procedures

The Enrollment Broker must develop policy and procedure manuals for each program (MEDALLION, Medallion II,) in conjunction with the Department for each of the Enrollment Broker functions. The policies and procedures must ensure accuracy and consistency and ensure against fraudulent enrollment. Policy and procedure manuals must contain workflows for the provision of required functions, to include but not limited to, incoming call process, outbound call process, plan changes, exclusion requests, twelve month enrollment process, and panel maintenance. The workflows shall include time frames for completion of function, where applicable, and must be approved by the Department. The roles, responsibilities, recipient and organizational contacts, and protocols and procedures for all Enrollment Broker Staff must be included.

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The first draft must be presented to the Department within 30 business days of contract award. The Department will provide comments within 14 business days. The Enrollment Broker must revise and return for final Department approval within 14 business days. The approved policies and procedures will be kept in a clear and up-to-date procedural manual.

It is expected that these manuals shall be used as training tools, and subsequently as references when performing enrollment activities. It is expected that all staff at the call center, including the primary and any secondary sites, if applicable, will have updated procedural manuals to aid them in answering recipient questions and processing enrollments. The manual shall include a module on the MEDALLION, Medallion II, programs containing specific scripts for staff use.

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The manual must be reviewed at least every six months for accuracy and must be updated as needed, and shall incorporate all revisions as provided by the Department, including but not limited to process updates by email, memo, etc. All updates must be forwarded for the Department's review and approval before dissemination.

The Department must be provided with both a hard copy and an electronic copy of the manuals at implementation, upon additional updates, and upon request.

3.21 Problem Resolution Process

The Enrollment Broker shall respond to and make its best efforts to resolve non-clinical managed care related inquiries and complaints from recipients, prospective recipients, people assisting recipients or acting on behalf of recipients, including family members, other state agencies, advocates or private

agency providers. These inquiries and complaints may include, but are not limited to, access to health care and services, receipt of enrollment information including identification cards, transportation coordination, dissatisfaction with provider or health plan, and non participation of providers or hospitals in health plans. Such responses and resolutions shall be HIPAA compliant and in accordance with the Department's policies and procedures and clearly documented in the Enrollment Broker's complaint tracking system.

Complaints forwarded to the Department for resolution that are determined to be within the Enrollment Broker's ability to resolve will be returned for immediate resolution. The Enrollment Broker has the initial responsibility for helping recipients to resolve managed care issues and complaints.

The Enrollment Broker must provide information on how to access the Department's and the MCO's internal grievance/appeals procedures, guiding the recipient through the process, documenting problems or complaints with providers and the MCOs which have not been satisfactorily resolved, and notifying the Department and the MCO, if applicable, of the problem. The Enrollment Broker shall document the resolution and the date of the resolution. Details regarding the Department's appeals process is available on the DMAS website at http://www.dmas.virginia.gov/app-home.htm. Details on Medallion II grievances and appeals is available in the Medallion II contract, available on the DMAS website at http://www.dmas.virginia.gov/mc-home.htm.
The Customer Service Representatives shall also work with the recipients to take a proactive position in informally resolving non-clinical problems before they enter the grievance process, or provide the proper referrals. These efforts must be clearly documented on the complaint log and reported to the Department weekly and monthly. If additional follow up is required by the Department on weekly complaints, the Enrollment Broker shall clearly note in the resolution summary information follow up is needed by the Department.

Deleted: Details on VALTC MCO grievance and appeals procedures is provided. VALTC MCO contracts are available on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm. ¶

3.22 Recipient Call Tracking System

The Enrollment Broker shall be responsible for establishing a database for logging calls by program (MEDALLION, Medallion II, and other) about MCOs and PCPs and other providers received through the HelpLine or other sources. The system must include, at a minimum, the recipient's name, Medicaid identification number, type of program (MEDALLION, Medallion II,), type of call, length of call, telephone number when available, name of the MCO and pertinent staff, when appropriate, name of the PCP, and other providers, information concerning the nature of the call, a record of the date of receipt of the call, the resolution and/or if additional follow-up required and any other information the Department specifies. This information must be reported to the Department weekly, monthly and annually.

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As part of the call tracking system, the Enrollment Broker shall report separately on complaints (weekly, monthly, and annually). Complaints requiring the immediate attention of the Department must be reported daily, following the occurrence, via phone or secure email notification. The six (6) categories of complaints for tracking purposes should include but are not limited to: Transportation, Access to Health Services/Providers, Provider Care and Treatment, MCO Customer Service, Administrative Issues, and Reimbursement.

3.23 Enrollee Education

Educational services shall be made available to the populations covered under this RFP. Education shall be provided to newly eligible Medicaid/FAMIS Plus recipients as well as to recipients who are currently or have been previously enrolled. This task requires a series of activities, the end purpose of which is the enrollment of an informed Medicaid/FAMIS Plus population into managed care programs. After completing a preliminary security screening, the Enrollment Broker shall verbally provide information to parents, guardians or other representatives who contact the HelpLine, to include but not limited to:

- The importance of receiving primary and preventive care, including immunizing children, how to get information about the type and frequency of required immunizations, and well child visits;
- The Women, Infants, and Children's (WIC) program, and contracted baby care programs;
- Primary Care Provider (PCP) and specialty care providers, including long-term care providers, in managed care;
- Program changes such as the twelve-month enrollment, expansions, open enrollment processes, etc. The Department shall provide in-service training to the Enrollment Broker regarding program changes. The Enrollment Broker shall ensure the dissemination of accurate information about the changes to all internal staff.
- EPSDT (Early and Periodic Screening Diagnosis and Treatment) services available for eligible recipients under age 21, as described in the section below.
- Information on dental screening and refer recipients to the Medicaid dental contractor - Smiles for Children Help Line, as appropriate.
- Care coordination assistance available through the member's MCO for Medallion II participants.

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3.24 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, the Social Security Act requires that medically necessary health care services be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. Under EPSDT, Medicaid children have access not only to well child visits, but also lead testing, developmental screenings, personal care, nursing, hearing aids, and specialized mental health and rehabilitative services for complex neurological and physical health conditions.

The Department routinely sends notices to EPSDT eligible recipients (MCO and Fee For Service) as a means of educating them of necessary and available services as well as how to access these services. These materials describe:

- The benefits of preventive health care and the importance of having a PCP;
- Medical screenings (including immunizations), vision, hearing and dental screenings;
- The importance of staying up to date with well child visits and shots;
- Information on when screenings are due for their child(ren);
- Information on the importance of lead testing; and,
- Information on how to access these services.

At a minimum, the Enrollment Broker shall:

- Advise managed care enrollees of EPSDT; the importance of keeping up with well child care visits and immunizations; and that these services are covered at no cost to the enrollee;

- Include links (English and Spanish) to the Department's Staying Healthy web-page, http://www.famis.org/stayinghealthy as well as links to other helpful websites and/or EPSDT resource information as requested and/or approved by the Department.

- Refer enrollees to the appropriate entity (MCO or DMAS) for special assistance.

Copies of the letters currently sent by the Department to recipients are available as is XVIII, XIX, XX and XXI of this RFP. In addition, the table below highlights the types of letters that are currently sent.

EPSDT Letter Type
EPSDT Welcome Letter – sent to new Medicaid children under age 21.
Monthly Birthday Cards/Newsletter – sent to enrollees in the Medicaid program during the month of their birthday. These letters educate children and their parents about the EPSDT program, the importance of keeping up with well child visits and immunizations.
Lead testing and elevated blood lead notices – In collaboration with the Virginia Department of Health, the Department receives information from VDH on children who have been screened and found to have elevated lead levels. These letters are sent to urge parents to proceed with follow-up testing.
Lead letter # 2 – These letters are sent as a reminder and follow-up, to the parents of a subset of the children identified for the letter above, where statistics indicate that the child remains in need of follow-up testing.

3.25 Virginia Medicaid Program Specific Knowledge

The Enrollment Broker must develop expertise in managed care philosophy in general and the Virginia Medicaid/FAMIS Plus delivery systems in particular. The Enrollment Broker must become familiar with the organization and goals of the Department as they relate to managed care and

recipient enrollment. The Enrollment Broker shall meet with the Department's Long-Term Care and Health Care Services Divisions to gain an understanding of the managed care programs, including the similarities and differences between MEDALLION, Medallion II, services and populations. Information on MEDALLION, Medallion II, is available on the Department's website at the following links: http://www.dmas.virginia.gov/mc-home.htm

The Enrollment Broker must meet with each MCO to obtain detailed information about the MCO's recipient operations for Medallion II. These meetings must take place within 30 business days after the contract has been awarded and subsequently on an annual basis. The Enrollment Broker must identify a liaison at each MCO to foster ongoing communication between the Enrollment Broker and each MCO. The Enrollment Broker shall notify the Department of any health plan changes on a monthly basis.

The Enrollment Broker must become familiar with the specific providers in each county that make up the network of contracted providers for each MCO. Knowledge of the location of practitioners, hospitals, clinics, etc. will be necessary to assist recipients in MCO selection. Refer to Section 3.29 for additional information.

The Enrollment Broker must be alert to possible discrepancies between the MCO's approved materials and actual practices as they are reported by recipients. Any discrepancies discovered should be documented and forwarded to the Department for review.

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3.26 Virginia Medicaid Management Information System (VAMMIS)

In response to this RFP, the Offeror must demonstrate the ability to interface with the VAMMIS system and through our fiscal agent to provide data and other information to the Department. The Enrollment Broker interface with VAMMIS will include MEDALLION, Medallion II, participant enrollment information. The Enrollment Broker shall have adequate personnel and resources in place to meet the following standards and procedures regarding receipt, processing and transmission of program information. All Enrollment Broker staff must have access to equipment, software and training necessary to accomplish their stated duties in a timely and efficient manner. The Enrollment Broker will supply all hardware, software, communication and other equipment necessary to perform the duties described herein. The Enrollment Broker should allow sufficient time for installation, configuration, and testing of the data line and associated equipment before putting it into production.

3.27 VAMMIS Connectivity

The Enrollment Broker shall be responsible for providing connectivity to the VAMMIS. Any expenses, including equipment, services, etc., incurred in establishing and maintaining connectivity between the Enrollment Broker and the Fiscal Agent hosted VAMMIS system will be the responsibility of the Enrollment Broker.

It is the responsibility of the Enrollment Broker to ensure that bandwidth is sufficient to meet the performance requirements of this RFP.

For the Enrollment Broker to interface with the VAMMIS, the Enrollment Broker will need to acquire, install, and make operational a software package called ClientBuilder TN3270 from Neon Systems Incorporated, on all workstations and load any new VAMMIS GUI screen updates.

The Fiscal Agent will only provide the VAMMIS GUI screen files, which were developed using ClientBuilder. The Enrollment Broker will work directly with the Fiscal Agent to coordinate the install and update of the Enrollment Broker's installed base of Client Builder as each release of new VAMMIS screen updates is made available. If the Enrollment Broker already has a direct data line connection to the fiscal agent (VAMMIS), an additional data line is not necessarily required. The existing data line may be used for the requirements of this RFP provided that the combined use of the line does not adversely impact the performance requirements of this RFP. That is, the bandwidth of the current line may have to be increased at the Enrollment Broker's expense to accommodate combined usage. However, multiple connections to the fiscal agent from the same location are not desirable.

Currently, the Fiscal Agent provides two methods of connectivity for VAMMIS access:

1. Private dedicated circuit.
2. Site to site Virtual Private Network (VPN), via Internet.

These two connectivity options are described in detail in the following sections.

Private Connection

The Fiscal Agent's Phoenix Data Center (PDC) supports DS3 Frame Relay connections to two carriers (MCI Option 1 & AT&T). The Fiscal Agent provides and maintains the shared access routers and local loops into the PDC. The Enrollment Broker maintains all connectivity/equipment at their location. The Enrollment Broker pays for the PVC between sites. If connectivity redundancy is required, an Enrollment Broker is allowed to establish connections to both carriers.

The Enrollment Broker can also deliver any router(s)/carrier(s) connectivity into the PDC at their own expense. Allowing for available bandwidth, the Fiscal Agent can allow the Enrollment Broker's local loop to ride the PDC Private Sonet Ring. The Enrollment Broker is responsible for the maintenance of all supplied equipment. PDC staff will validate power and physical connectivity for the equipment.

Site to Site VPN

The Cisco 3060 VPN Concentrator located at PDC offers support for up to 5000 simultaneous IP Security (IPSec) sessions. The 3060 is a VPN platform designed for large organizations that require the highest level of performance and reliability and that have high-bandwidth requirements from fractional T3 through full T3/E3 or greater (100 Mbps maximum performance).

The Enrollment Broker can also deliver a VPN device to be hosted in an isolated "Extranet VLAN". VPN traffic will be tunneled through the Internet Firewall's to the VPN device for decryption/delivery to the DMZ Firewall. The Enrollment Broker is responsible for the maintenance of all supplied equipment. PDC staff will validate power and physical connectivity for the equipment. A Site to Site IPSEC VPN can be established between the Enrollment Broker and the Fiscal Agent Cisco 3060 VPN concentrator. The VPN will secure all traffic passing between the sites. The Concentrator and Firewalls will restrict the physical access to only allowed hosts.

The Site to Site configuration will allow workstations to communicate via the TN/3270 protocol to the VAMMIS running on the Verizon mainframe, and to view the VAMMIS Online Documentation via the HTTP protocol running on Web Servers hosted in the PDC Data Center.

3.28 Recipient Database

The Enrollment Broker will create and maintain a recipient database. The Enrollment Broker's database must include documentation regarding all calls taken or enrollments by mail, including inbound or outbound calls, regarding assignments, transfers, disenrollments, and exclusions by Department determined reasons or reason codes. The Department will provide enrollee and enrollee case VAMMIS data extract files on a monthly basis to the Enrollment Broker, and the Enrollment Broker will use these data extracts to maintain and update their recipient database. File layouts for each of these files are provided in Attachment XVII. The Department shall identify to the Enrollment Broker on a monthly basis the program in which the enrollee participates (MEDALLION, Medallion II, or VALTC). Each of the extract files provided represents full-file replacements.

The Enrollment Broker's system shall also create a monthly recipient phone number list to include, by MCO, recipient ID and phone number changes/updates. The Enrollment Broker shall post this phone number list weekly via bulletin board and monthly for Department and MCO downloads.

All data contained within the Enrollment Broker's recipient database is the property of the Department and shall be provided to the Department upon contract termination.

Reporting from the Enrollment Broker recipient database is described in Section 4 of this RFP.

3.29 HIPAA Requirements

The Enrollment Broker is expected to comply with the Health Insurance Portability and Accountability Act (HIPAA) Final Rules and Standards related to the electronic transactions of data between the Enrollment Broker and FHSC, electronic correspondence between the Enrollment Broker and DMAS, and transmission within and out of the Enrollment Broker's corporate network including any ISPs. These HIPAA standards involve:

- The Privacy of Individually Identifiable Health Information;
- Standards for Electronic Transactions; National Standards for Employer Identifiers;
- National Standards for Health Care Provider Identifiers; and,
- HIPAA Privacy and Security Regulations.

The Enrollment Broker will be expected to provide DMAS with a written Security Plan that describes the use of data that will be transmitted to DMAS or the fiscal agent or reside in the custody of the Enrollment Broker. The fiscal agent may also require an executed HIPAA trading partner agreement with the Enrollment Broker.

3.30 MEDALLION Provider Panel Maintenance

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The Enrollment Broker shall receive a hard-copy MEDALLION primary care provider (PCP) Listing from the Department's mailing Contractor. This listing will have open, history or closed panel information. The Enrollment Broker may download from the DMAS mailing Contractor's website on a monthly basis and download into their internal database. See Attachment XXVI for the file formats.

Providers may request that recipients be added or deleted from their panels. If a MEDALLION primary care provider has a closed panel, he or she may request recipients be added or deleted from their panels. The provider has to call the Enrollment Broker or fax the "Provider-Recipient Assignment Request" to the Enrollment Broker to add recipients to his/her panel. A sample request form is enclosed in this RFP. The Enrollment Broker must ensure that MEDALLION PCPs follow established procedures when submitting requests to make a change to their panels. The Enrollment Broker must follow the Department's established procedures and time frames for opening and closing provider panels for recipient enrollment. The Enrollment Broker is responsible for handling all provider panel requests within one (1) business day that are received through the Managed Care HelpLine and those faxed from providers. Providers have to provide a written explanation to the Enrollment Broker or the Department of the reason they wish to delete a recipient from their panel. For provider recipient assignment requests received after the VAMMIS managed care cutoff date, the Enrollment Broker shall notify the provider regarding the associated delay of provider recipient assignment.

3.31 Managed Care Organization (MCO) Provider File

The Enrollment Broker shall receive and load a full monthly provider file, including all provider types and specialties, from each of the Department's contracted MCOs. See Attachment XXVIII for the file format. For the MCOs who participate in both Medallion II, the Enrollment Broker shall receive and download separate provider files from each MCO. Further, the Enrollment Broker shall utilize the correct MCO's provider file, when answering questions from Medallion II participants. MCO provider files will include, but not be limited to, primary care providers, specialists, ancillary providers, hospitals, home health, durable medical equipment, , and pharmacies. The Enrollment Broker must work with the Department and the MCO regarding an acceptable format to accept consistent values for provider specialty designations for the provider files. The correct MCO provider file information shall be available to the customer service representatives to answer questions from recipients regarding where their providers participate, by health plan, and program (MEDALLION, Medallion II,) in order to assist recipients in making the most appropriate MCO choice to meet their health care needs.

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3.32 MCO and PCP Provider Network DataBase

The Enrollment Broker shall create a comprehensive provider network database, that incorporates the MCO provider file information described above, and that includes PCP specific information for MEDALLION, Medallion II, which includes, but is not limited to:

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a. Provider name
b. Provider class types (e.g., physician, general hospital, home health, pharmacy, etc.)
c. Provider specialty (e.g., OB-GYN, pediatrics, cardiologist, etc.)
d. NPI/API number

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e. Existing Medicaid panel slots for all MEDALLION and MCO PCPs
f. Open/available/closed Medicaid panel slots for MEDALLION and MCO PCPs
g. Street address (physical location)
h. City/town as it appears on the mailing address (physical location)
i. Zip codes
j. Telephone number
k. Language abilities

The Enrollment Broker provider data base shall include, at a minimum, information on maximum enrollment in MEDALLION primary care physician panels; an on-line edit to disallow enrollments into filled panels; an edit to prevent health plan disenrollment without simultaneous enrollment into another health plan; office locations, schedules, and telephone numbers of primary care physician offices, and special requirements or services of the PCP (hospital and specialist referrals, languages, populations served, etc.). The Enrollment Broker must acquire monthly enrollment updates or more frequently if required (i.e., program changes, expansion periods, etc.) of the provider file from the MCO. The Enrollment Broker must work with the Department and the MCO to assure all data are provided in accordance with the provider network database requirements. The Enrollment Broker provider network file shall allow for the flexibility to accommodate full replacement data and additional provider class and specialty types at no additional cost to the Department. This file must be provided upon request to the Department.

The provider network database shall also include information like provider location, languages spoken, telephone numbers, etc. on specialty providers, including long-term care providers.

3.33 Enrollment Broker System Changes Fee

The Enrollment Broker may be reimbursed for system changes made at the request of the Department in excess of forty hours for each systems change. In its cost proposal submission, the Offeror must provide a reasonable hourly rate charge for each system change in excess of forty hours.

3.34 Virginia Managed Care Website

The Enrollment Broker shall design and develop a basic informational website for Virginia managed care to be named www.virginiamanagedcare.com/http to be used on a shared server and compliant with the Virginia Information Technology Accessibility (VITA) Standards. The current VITA standards are published at http://www.vita.virginia.gov/docs/websiteStandards.cfm.

The Enrollment Broker shall ensure that website is also available in Spanish translation for each page of the website. Routine updates shall be made by the Enrollment Broker upon request by the Department at no cost; i.e. updates to What's New Section and/or announcements.

The Enrollment Broker shall also assure that the website technology includes web trending software to track the utilization of the site; i.e. total visits, total page views, top page, etc., with monthly comparison reports to the Department. The Enrollment Broker agrees to relinquish ownership of the website upon contract termination, at which time the Department shall take title to this web address and its contents.

Features of the website shall include, but may not be limited to:

- Information on how to enroll in MEDALLION or an MCO (Medallion II)
- List of MCOs, phone numbers and website links for each health plan
- Open enrollment dates and comparison charts for cities/counties in Virginia
- What's New section for upcoming events and special announcements
- Frequently asked questions and answers
- Materials (brochures/comparison charts) – ability to print
- EPSDT related web links, including the link to the Department's Staying Healthy web page at http://www.famis.org/stayinghealthy

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3.35 Relationship with MCOs and Other Agencies

The Enrollment Broker must work cooperatively with staff at central and local DSS, Virginia Department of Health (VDH), Department of Mental Health Mental Retardation Substance Abuse Services (DMHMRSAS), Community Services Boards (CSBs), contracted MCOs and other community organizations. The Enrollment Broker shall provide education about the enrollment process, managed care, facilitate problem resolution and maintain open communication as calls are received through the HelpLine, to enhance enrollment activities.

3.36 Meetings

The Enrollment Broker shall participate in meetings with the Department, the MCOs, Quality Assurance Committees, or any other groups as necessary to meet its obligations under the Enrollment Broker Contract. The Enrollment Broker key personnel shall meet with a Department Representative (Contract Monitor) bi-monthly and maintain meeting minutes.

3.37 Program Implementations, Expansions and Changes

The Enrollment Broker shall be responsible for providing enrollment functions as required in this RFP and in Offeror's proposal during new program implementation, new MCO participation in a Medallion II region, and expansion of the MEDALLION and Medallion II managed care programs into other areas of the Commonwealth. Contract standards and quality of services shall be maintained during these occurrences. Any additional staff, equipment and/or associated costs shall be the responsibility of the Enrollment Broker.

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If any one of the Managed Care Programs (MEDALLION and Medallion II) are eliminated or experiences a decrease in the number of eligible participants of at least 20% or more from the actual enrollment reflected at the time of the implementation of this contract, the parties shall enter into good faith negotiations and shall agree upon revised payment terms to adjust to the change in volume. Data that resides at the Department shall serve as the final authority for determination of volume. The Department will notify the Contractor of any deletions of programs and/or populations and its projected impact on payment at least 90 days prior to the effective date of the deletion of program and/or population.

Deleted: The Enrollment Broker shall be responsible for providing enrollment functions as required in this RFP if the Department expands VALTC into new areas of the Commonwealth. The Department may negotiate additional reimbursement for these expansions based upon VALTC call volume data derived from experience by the Enrollment Broker in the Tidewater area.

3.38 Program Integrity

The Enrollment Broker shall have a plan for program integrity with internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

The Enrollment Broker shall have a written Fraud and Abuse compliance plan. The Enrollment Broker's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Enrollment Broker for review and approval by the Department with this RFP and as an annual submission as part of the Contract. The Plan must define how the Enrollment Broker will adequately identify and report suspected fraud and abuse. The Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The Enrollment Broker shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

The Enrollment Broker shall report incidents of potential or actual fraud and abuse to the Department within one (1) business days of initiation of any investigative action by the Enrollment Broker or within one (1) business days of Enrollment Broker notification that another entity is conducting such an investigation of the Enrollment Broker. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Enrollment Broker shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal offices. The Enrollment Broker shall provide an annual report to the Department of all activities and results.

3.39 Transition Upon Termination

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Enrollment Broker. See Section 10.5 for more information on termination of contract. Any contract cancellation notice shall not relieve the Enrollment Broker of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation. At the end of the contract, the Enrollment Broker shall transfer the toll-free number(s) and any web-based resources, including the website, back to the Department. Additionally, the Enrollment Broker shall assist in the transitioning of services. Upon termination of the contract, the Department shall pay the Enrollment Broker the value of services performed up to the date of termination, not to exceed the total value of the contract.

3.40 Optional Enrollment Broker Services

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The Department is interested in the Offeror's capabilities and expertise with the following *optional* services. These services may be implemented at some point within the duration of the contract resulting from this RFP. Information in the Offeror's technical proposal must describe the Offeror's abilities, experience, and method(s) for accomplishing these services at a reasonable cost to the Commonwealth. The Offeror's cost shall be submitted separate from the technical proposal for each of these optional services per Attachment III (c).

A. EPSDT Helpline Central Point of Contact - Operation of an EPSDT HelpLine, complete with toll-free assistance, member education, and call tracking/reporting for all Medicaid fee-for-service and MCO enrollees. When implemented, this would allow the Department to list the Enrollment Broker as the central point of contact on all EPSDT related communications, including but not limited to the DMAS Website, Managed Care Helpline Website, Department and MCO EPSDT related mailings, etc. Sample EPSDT communications are included as Attachments XVIII - XXI of this RFP.

B. Enhanced Technology - Development and implementation of enhanced technological enrollment capabilities, including but not limited to, interactive website features; secure on-line enrollment submission and processing; secure on-line HSA completion and processing; enrollment submissions using interactive voice response (IVR) technology, and other enrollment related opportunities using state-of-the art technological solutions that increase efficiency, minimize cost, and maximize customer satisfaction.

C. Conduct Health Status Assessments (HSAs) for Additional Populations – Conduct HSAs for MEDALLION participants with referral to the Disease Management Contractor.

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4. REPORTING AND DELIVERY REQUIREMENTS

The Enrollment Broker shall submit accurate and all-inclusive management reports to the Department at the following intervals: weekly, monthly (cumulative to show quarterly), annually, as specified herein, or on demand. The Enrollment Broker shall demonstrate experience in data accumulation and in writing reports that are well organized, clear, concise and readable by lay persons. All reports, analyses, and/or publications developed under this Enrollment Broker will be the property of the Department. The Offeror must submit sample reports reflective of the Offeror's proposed technology and abilities; and in following with the requirements described in this RFP; as part of its submission proposal.

The Department reserves the right to change reporting requirements with sufficient notice (30 days). In addition, the Department may request ad hoc reports to be delivered within 3-5 business days. This timeframe can be extended if necessary depending upon the nature of the report. The Department will determine reporting format. Monthly reports should be cumulative, and have quarterly and annual summaries. At a minimum, the Enrollment Broker shall provide the following management reports to the Department in the frequency and format indicated below.

Reports from the Enrollment Broker's ACD or internal operating system (i.e., reporting volume stats for incoming calls, average talk time, outgoing calls, speed to answer, abandonment rate, etc.) shall provide separate statistical analysis by program (MEDALLION, Medallion II).

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4.1 Timeline of Reports

Weekly reports are due to the Department by close of business the first business day of the following week. Monthly reports are due by the 15th of the following month. Cumulative quarterly reports are included in the monthly as a separate report. Annual reports are due within the last month of the quarter following the end of the contract year.

4.2 Reports and Schedule of Delivery:

- **Busy Hour Report:** Reflects the number and percentage of calls answered each hour per day (monthly).

- **Complaint Report**: Includes reporting of complaints by program (MEDALLION, Medallion II), and all of the following data elements: MCO Name (or PCP Name for MEDALLION), type of complaint, major category, resolution, any information about an appeal, if available, and other criteria established by the Department. The Enrollment Broker is responsible for notifying the Department of any complaint that requires the immediate attention of the Department, as frequently as needed, via phone, email or weekly complaint log (weekly/monthly).

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  - The six (6) major categories of complaints for tracking purposes should include but are not limited to: Transportation, Access to Health Services/Providers, Provider Care and Treatment, MCO customer service, Administrative Issues, and Reimbursement issues. Sub-categories shall be provided for each major category.

- **Conflict of Interest/Ownership Reporting:** Freedom from conflict of interest and ownership/control information in accordance with requirements described in Section 3.1, 7.6, and Attachment XXV of this RFP.

- **Disenrollment/Plan Change Report:** By program, (MEDALLION, Medallion II) reports recipient changes from one MCO to another. Includes the recipient's name, ID number, address, telephone number, old MCO, new MCO, date of contact and the reason for the change. The Enrollment Broker is also responsible for developing a Plan Change Report by program for each MCO identifying the old MCO, new MCO, the reason for the change and the number of recipients who changed for that month (monthly).

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- **DSS Address Discrepancy Notification Report:** Includes discrepancies found in recipient information that requires further research and correcting. This may include, but is not limited to, recipient's name, address, date of birth, social security number (weekly).

- **Enrollment Activity Report:** By program (MEDALLION, Medallion II), includes, at a minimum, completed enrollments per MCO and MEDALLION (monthly).

- **Exclusion Report**: By program, (MEDALLION, Medallion II), records recipient exemptions and the reasons for exemptions in accordance with DMAS guidelines (weekly/monthly).

- **Financial Statements:** Audited quarterly financial statements as filed with the Securities and Exchange Commission.

- **Fulfillment Packets**: By program (MEDALLION, Medallion II), indicates the number of requests for information and the distribution by locality (monthly).

- **Health Status Assessment Report (Medallion II)**: By MCO, includes the total number of recipients who received an assessment by MCO and the date; format mailed or posted to bulletin board to the MCO (weekly, monthly).

- **Helpline Activity Summary Report:** Summarizes, at a minimum, (and separately by program) the number of incoming calls, the number of answered calls, the average call wait time, the average talk time (4-5 minutes), the number of calls answered within three (3) minutes, the number and percentage of calls placed on hold and the average hold time, the number and percentage of abandon calls, the average length of time within (3) minutes until calls abandon, the number of calls in the queue at peak times and wait times for calls in the queue, the number of outbound calls and daily number of agents available.

- **Monthly HelpLine Activity Report:** By program, (MEDALLION, Medallion II,) includes, at a minimum, total types of calls logged into database; i.e.: address changes, complaints, enrollment, exemption requests, good cause, provider, fulfillment, eligibility, etc. and total calls and percentage for each category (monthly).

- **Language Line:** By program, (MEDALLION, Medallion II,) reports the different languages provided by the service, the number of calls associated with each language, the total incoming calls, percentage of incoming calls requiring language line assistance, overall and per language (monthly).

- **Calls in Queue Per Operator:** Provides summary showing the number of calls in queue per operator; no more than three calls in queue per operator at any time in a half-hour segment (monthly).

- **Managed Care Website Monthly Activity**: Provides daily, weekly and monthly number of visits and page views for the month, with information on the most viewed page. Year-to-date data to include busiest day, average visits per day and length of visit and month to month comparison data (monthly).

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- **Staffing Report**: Provides a listing of Enrollment Broker's staff and titles (monthly).

- **Organizational Chart:** Provides functional units and names of key personnel (semi-annually).

- **Monthly Recipient Updated Phone Number List**: Create a recipient phone number listing using the Enrollment Broker's recipient database, by MCO health plan, that lists the recipient ID and phone number. Phone number updates will be shared by the Enrollment Broker with the MCOs weekly via bulletin board.

4.3 Disaster Preparedness and Recovery Plan

The Enrollment Broker must submit evidence that it has a Business Continuity/Disaster Recovery (BC/DR) plan in place for its overall operations, including, but not limited to, the call center, enrollment processing, web-based operations, and information systems. The Plan document must be certified and delivered to the Department as part of the RFP response. The results of the annual testing of the plan must be made available upon request to the Department for the life of the contract.

The Enrollment Broker's BC/DR plan shall address all of the following:

- The ability to continue receiving calls, processing enrollment, and other functions required in this RFP in the event that the central site is rendered inoperable.
- Provisions in relation to the call center telephone number(s).
- Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc.
- Provisions that the plan be tested annually after the effective date of the contract.
- Provisions to assure that employees at the site are familiar with the emergency procedures.
- Smoking must be prohibited at the site.
- Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable) and these devices must alert the local fire department as well as internal personnel.
- Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.
- The site must be protected by an automatic fire suppression system.
- The site must be backed up by an uninterruptible power source system.

The RFP response must include sufficient information to show that the plan meets or exceeds the requirements of final rule adopting HIPAA standards for security as published in the Federal Register, Volume 63, # 34 on February 20, 2003 and complies with the guidance provided in the following:

- Virginia Information Technologies Agency (VITA) Information Technology Resource Management Security Standards at http://www.vita.virginia.gov/
- Federal Preparedness Circular 65, updated June 2004
- National Institute of Standards and Technology (NIST) Special Publications

800-66; An Introductory Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, dated March 2005
800-34 Contingency Planning Guide for Information Technology Systems

- Virginia Department of Emergency Management Continuity of Operations planning toolkit at http://www.vaemergency.com/library/coop/resources/index.cfm.

5. DEPARTMENT RESPONSIBILITIES

The Department shall provide a contract monitor to maintain communication with the Enrollment Broker. The Department shall meet with the Enrollment Broker representative on a bi-monthly basis and daily communication (if needed) to discuss the Enrollment Broker activities. During such, issues such as enrollment questions, VAMMIS system problems, project plan and education plans etc., will be addressed.

The functions and duties of the Department shall include but are not limited to the following:

1. The Department shall have final authority and responsibility for excluding individuals from the managed care programs.
2. The Department shall establish guidelines for entering managed care recipient data into the VAMMIS, electronically.
3. The Department shall provide, through its contracted mailing vendor, copies of letters for informational purposes to be mailed to managed care eligible recipients, including monthly, open enrollment, etc.
4. The Department shall work with the Enrollment Broker and MCOs to facilitate the process of establishing an FTP site to facilitate the exchange of information to and from the MCOs to include provider data files, completed HSAs, etc.
5. The Department shall provide the Enrollment Broker the enrollment cut-off date (MMIS schedule) six months in advance or as soon as the information is available to the Department.
6. The Department shall assist the Enrollment Broker in acquiring access to VAMMIS on weekends and holidays, as needed.
7. The Department shall approve print materials, policy and procedural and training manuals, scripts, after hours messages (as applicable), website updates, provider file format, etc.
8. The Department shall provide in-service training to the Enrollment Broker staff as required for implementation of the Enrollment Broker contract and shall notify the Enrollment Broker of on-going program changes.
9. The Department shall perform monitoring and quality assurance activities to ensure that the Enrollment Broker adheres to the policies, procedures and regulations of the Department by conducting audits of the Enrollment Broker's operations at any time, including but not limited to call center operations, Managed Care Helpline activity, Automated Call Distributor reports, system's functions and activities.
10. The Department shall assist in the resolution of issues and complaints determined to not be within the Enrollment Broker's ability to resolve as agreed upon by the Department and the Enrollment Broker.
11. The Department shall train the Enrollment Broker on panel maintenance procedures to include opening and closing PCP panels.

12. The Department shall have regional annual open enrollment periods where managed care recipients can change MCOs or PCPs without cause.
13. The Department shall approve the Enrollment Broker's reporting format and reserves the right to change reporting requirements as needed and to request ad hoc reports if needed.
14. The Department shall notify the Enrollment Broker of contract compliance issues and designate a period of time for the Enrollment Broker to provide a written reply.
15. The Department shall provide notice as specified in the contract of intentions to renew or terminate the contract.
16. The Department through its Fiscal Agent shall provide the Enrollment Broker a monthly extract of case and recipient eligibility data.
17. The Department shall provide follow up call monitoring summaries to key staff after auditing of calls by representative.

6. METHOD OF PAYMENT

Yearly the parties shall agree upon a fixed price to be paid for the services related to this contract. Provisions for renegotiations shall be made for substantial increases or decreases in anticipated workload. The Department will not be held responsible for additional charges in relation to call increase due to open enrollment or program changes.

For the MEDALLION and Medallion II populations, the Department shall only pay for calls answered by staff members and will not reimburse for overage calls unless call volume exceeds 40% of the anticipated volume of all managed care programs. Call volume for MEDALLION and Medallion II programs that exceeds 40% of the total estimate would be eligible for additional reimbursement. The Offeror must include in its cost proposal a reasonable charge (per 100 calls) for call volume in excess of more than 40% of the total call volume projected.

If any one of the Managed Care Programs (MEDALLION and Medallion II) are eliminated or reflect a decrease in the number of eligible participants of at least 20% or more from the actual enrollment reflected at the time of the implementation of this contract, the parties shall enter into good faith negotiations and shall agree upon revised payment terms to adjust to the change in volume. Data that resides at the Department shall serve as the final authority for determination of volume. The Department will notify the Contractor of any deletions of programs and/or populations and its projected impact on payment at least 90 days prior to the effective date of the deletion of program and/or population.

Invoices reflecting call volume by program shall be submitted monthly on the last day of the month, beginning with the month of implementation, by the Enrollment Broker to:

Department of Medical Assistance Services
Accounts Payable, Division of Fiscal and Procurement
Suite 1300
600E Broad Street
Richmond, VA 23219

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¶
If the VALTC program is eliminated or reflect a decrease in the number of eligible participants or if the annual projected volume of calls has been overstated more than 20%, the parties shall enter into good faith negotiations and shall agree upon revised payment terms to adjust to the change in volume. Data that resides at the Department shall serve as the final authority for determination of volume. The Department will notify the Contractor of any deletions of programs and/or populations and its projected impact on payment at least 90 days prior to the effective date of the deletion of program and/or population. ¶

Fax: 804-786-5799

All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors), or the federal employer identification number (for proprietorships, partnerships, and corporations).

In accordance with Section 3.33 the Enrollment Broker may be reimbursed for system changes made at the request of the Department in excess of forty hours for each systems change. In its cost proposal submission, the Offeror must provide a reasonable hourly rate charge for each systems change in excess of forty hours.

In addition to these requirements, all payments to the Enrollment Broker shall adhere to requirements described in Section 9.10 of this RFP.

7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements and the specific requirements for the Technical Proposal and the cost proposal.

7.1. Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that the Department may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

The proposal may include any additional information that the Offeror considers relevant to this RFP.

7.2 Critical Elements of the Technical Proposal

The Offeror must cross reference its Technical proposal with each requirement listed in Sections 3 and 4 of this RFP. In addition, the Offeror must ensure that the following documentation is included in the proposal.

Offeror's Qualifications: The proposal must include a summary of the Offeror's qualifications. The nature and importance of the work requires very strong qualifications. Documentation of directly

related experience and credentials is necessary. Special emphasis will be placed upon experience in performing similar services for State or Federal government human services organizations.

The Offeror must describe its experience, including length of time, working in the health care industry with particular focus on managed care, enrollment activities experience and the Medicaid/FAMIS Plus population. The response should include descriptions of current and previous contractual agreements, responsibilities, time periods, work performed, volume handled and enrollment processes currently used.

- Demonstrate its experience in Medicaid customer service and community outreach in the health care industry, including special needs populations.

- Describe its experience in the areas of marketing and public relations or the experience of any sub-Enrollment Broker it will employ.

- Describe its experience in operating a toll-free information line, including a description of the purpose of the toll free number, types of calls received, volume of calls, and telecommunications system used.

- Include a summary of technical and delivery systems used or interfaced in the above projects.

- Describe the Enrollment Broker's previous experience in services and operational functions in similar projects.

- Describe previous experience in providing specialized education and enrollment processes with itemized services for Acute and Long-Term Care population in a State organization.

- Describe prior experience and technological capabilities for operation of a comprehensive, state of the art call center, capable of responding to recipient concerns; providing recipient education; and handling enrollment activity for recipients with complex health care needs.

- Describe previous experience in the construction and maintenance of a website including the features required in this RFP.

Project Plan: The Offeror’s proposal must include a preliminary implementation plan as part of its response to this RFP. The implementation plan shall include a detailed project schedule including the tasks and deliverables required to accomplish the work in the Offeror’s proposal.

Implementation Plan: Submit a detailed implementation plan as part of the Offeror’s response to the RFP. The implementation plan must demonstrate the Enrollment Broker's proposed schedule to implement full operations within 30 days of contract award.

Enrollment Process: Submit a detailed description of the manner in which it proposes to perform the responsibilities detailed in Section 3 of this RFP. The plan must include a step by step description of the procedures by which a recipient is assisted in selecting the health plan of their choice.

Help Line Operations: Submit a detailed description of how it will properly staff and operate a toll-free Help Line(s), and how individuals will be identified by program including process for routine and emergency calls and including how recipients will be triaged to other appropriate resources. The plan must describe the information and assistance that will be provided by Representatives to recipients.

Deleted: In addition, describe the Offeror's plan for staffing for the VALTC program initiative.¶

Telecommunications System: Submit a description of a proposed system which meets the requirements of Section 3.

Staffing: The Enrollment Broker must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired to become Representatives, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Enrollment Broker's plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide or Policies and Procedures Manual.

Auditing: Submit a description of how all enrollment and education-related activities shall be audited by the Enrollment Broker, including the requirement that assistance in health plan selection be completely objective, and that Help Line responses are accurate. This section must also describe a plan to ensure confidentiality of recipient's records. Provide a copy of daily standard audit form used on internal staff to measure production scores by Enrollment Broker.

Miscellaneous: The Enrollment Broker must submit with RFP:

- A proposed Health Status Assessment tool and a description of how it will be administered
- Sample of reports and sample of member enrollment materials
- Statement attesting freedom from conflict of interest per Section 3.1 and Attachment XXV.

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Capacity Summary: The proposal must include a capacity summary (physical plant, equipment, and critical personnel) including a discussion of the Offeror's capacity to successfully provide the desired services in light of other potential and known demands upon those resources.

Summary of Key Staff: The proposal must include a staff summary and identification of key staff, to include a qualified project director/manager who will be working on the project, and their relevant experience. Professional resumes/and or detailed job descriptions for staff must be included with an indication of their area(s) of expertise (e.g. enrollment, call center, etc.).

References: The proposal must include a minimum of three references. In addition, the proposal must include references from all state governments, Medicaid business in particular, for which the Offeror is currently under contract with for similar services outlined in this RFP. Signatures from the state officials must be included on the reference submission in this RFP. Offerors who fail to provide all state references with official signatures shall fail to earn the maximum points under the evaluation criteria. The Offeror shall also include past and/or current commercial accounts for work of a similar nature (Attachment I).

Small Business Subcontracting Plan: The Offeror shall be required to submit, a report on the actual dollars to be spent with small businesses and small businesses owned by women and minorities during the performance of the contract. When such business has been subcontracted to these firms and

quarterly during the contract period, the Enrollment Broker agrees to furnish the purchasing office the following information: name of firm, phone number, total dollar amount subcontracted and type of product/service provided on a quarterly basis.

Names of Virginia certified firms may be available from the Department of Minority Business Enterprise at www.dmbe.virginia.gov. At a minimum, this report shall include for each firm contracted with and for each such business class (i.e., small, small-minority-owned, small-women-owned) the total actual dollars spent on this contract, the planned involvement of the firm and business class as specified in the proposal, and the actual percent of the total estimated contract value.

The Offeror shall submit a Small Business Subcontracting Plan for this procurement. Attachment II contains the format for providing this information, and shall be included in the package with the Offeror's Original of the Technical Proposal (Attachment II).

Organizational Structure: The Enrollment Broker must state its name, address, and telephone number, and provide:

- An organizational chart depicting the Enrollment Broker's organization in relation to any parent, subsidiary, and related organization.
- Significant subcontracts and assignment relationships.
- The names and occupations of the recipients of the Board of Directors of the organization(s).

Enrollment Broker's Financial Condition: The selected Enrollment Broker will be required to submit an audited financial statement for the two most recent fiscal years for which such audited statements are available which demonstrate the Enrollment Broker organization is in sound financial condition. Such documentation will be a condition of contract award.

Systems Interface Plan: This section shall describe the Enrollment Broker's existing computer capabilities and proposed enhancements or new capabilities specifically intended for this contract. This section should include a description of those functions that will be automated and a description of the hardware and software to be used. The hardware description should include the brand and model of the platform planned for the contract, the operating system and available peripherals. The software description should include a schematic overview of the system, volume capacities, file layouts, edits, language in which the software is written, and an estimate of the level of effort and time frames to modify the software for the purposes of this contract. The software description should also include the proposed methodology to interface with the VAMMIS and accept data from participating health plans.

Cost Proposal: The Enrollment Broker must submit the total costs as specified. The Cost Proposal (one copy) must be sealed separately from the Technical Proposal, and labeled "Cost Proposal." The Enrollment Broker is to submit costs on cost proposal sheets. Note that the Enrollment Broker may recreate its own cost sheet, but must use the format of the sample provided in Attachment III.

No cost information is to be included in any other portion of the proposal.

7.3 Binding of Proposal

The Technical Proposal shall be clearly labeled "Technical Proposal" on the front cover. The Cost Proposal shall be clearly labeled "Cost Proposal" on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit an original and six (6) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP " Technical Proposal". In addition, the original of the Cost Proposal shall be sealed separately and clearly marked "RFP " Cost Proposal" and submitted by the response date and time specified in this RFP. The Cost Proposal forms in Attachment III shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2000 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2000 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal.

7.4 Table of Contents

The proposal shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 3 and 4. Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist the Department in determining uniform compliance with specific RFP requirements.

7.5 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror's proposal. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror's collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

The Commonwealth agrees that neither it nor its employees, representatives, or agents shall knowingly divulge any proprietary information with respect to the operation of the software, the technology

embodied therein, or any other trade secret or proprietary information related thereto, except as specifically authorized by the Enrollment Broker in writing or as required by the Freedom of Information Act or similar law. It shall be the Enrollment Broker's responsibility to fully comply with § 2.2-4342F of the *Code of Virginia*. All trade secrets or proprietary information must be identified in writing or other tangible form and conspicuously labeled as "proprietary" either prior to or at the time of submission to the Commonwealth.

The Enrollment Broker assures that information and data obtained as to personal facts and circumstances related to patients or clients shall be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent. Any information to be disclosed, except to the agency, must be in summary, statistical, or other form which does not identify particular individuals. Enrollment Brokers and their employees working on this project shall be required to sign the Confidentiality statement in this solicitation.

Ownership of all data, materials, and documentation originated and prepared for the State pursuant to the RFP shall belong exclusively to the State and be subject to public inspection in accordance with the *Virginia Freedom of Information Act*. Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the *Virginia Freedom of Information Act*; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret materials submitted must be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. <u>The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of the Department, may result in rejection and return of the proposal.</u>

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, small-women-owned businesses and small-minority-owned business shall be submitted with the Technical Proposal.

7.6 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda.

At a minimum, the transmittal letter shall contain the following:

1. A Statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
   a) The Offeror and any related entities must identify any client relationships, contracts or agreements they have with any State or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program facility or Contractor and the general circumstances

of the contract or agreement. This information will be reviewed by the Department to ensure there are no potential conflicts of interest;

b) Offeror must be able to present sufficient assurances to the State that the award of the contract to the Offeror shall not create a conflict of interest between the Contractor, the Department, and its subcontractors; and

c) The Offeror must be licensed to conduct business in the State of Virginia.

2. A Statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;
4. Designation of an individual as the authorized representative of the organization who will interact with the Department on any matters pertaining to this RFP and the resultant Contract; and
5. A Statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to the Department.

7.7 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP as well as the cover page of the Addenda, if issued, to the RFP and submit this along with its proposal.

7.8 Procurement Contact

The principal point of contact for this procurement in the Department shall be:

Susan Offie, Contract Monitor
Managed Care Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail ebrfp@dmas.virginia.gov

All communications with the Department regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact or the Department Contract Management Officer. An Offeror who communicates with any other employees or Contractors of the Department concerning this RFP after issuance of the RFP may be disqualified from this procurement.

7.9 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at the Department no later than 2:00 p.m. E.S.T. on January 5, 2009. The Department shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:
Attention: William D. Sydnor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: William D. Sydnor
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

If the Department does not receive at least one responsive proposal as a result of this RFP, the Department reserves the right to select an Enrollment Broker that best meets its needs. The Department management shall select this Enrollment Broker. The Department also reserves the right to reject all proposals. The Department reserves the right to delay implementation of the RFP if a satisfactory Enrollment Broker is not identified or if the Department determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the DMAS web site at http://www.dmas.virginia.gov/ and the eVA web site at http://www.eva.virginia.gov

7.10 Oral Presentation and Site Visit

The Department may require one or more oral presentations or conference calls by an Offeror in response to questions it has about the Offeror's proposal. The Department will allow a minimum two-business day advance notice to the Offeror prior to the date of the oral presentation. Expenses incurred as part of the oral presentation shall be the Offeror's responsibility.

7.11 RFP Schedule of Events

The following RFP Schedule of Events represents the State's proposed timeframe that will be followed for implementation of the program.

EVENT	DATE
State Issues RFP	November 21, 2008
Letter of Intent	December 2, 2008
Deadline for Written Questions and Comments	December 2, 2008
Deadline for Submitting a Proposal to the Department	January 6, 2009
Implementation Date (Project Plan and Data Exchange)	April 1, 2009

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued to all Offerors by the Department. If supplemental releases are necessary, the Department reserves the

right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The RFP and subsequent information will be listed on the Department's website (www.dmas.virginia.gov) and the eVA website (www.eva.state.va.us). Offerors are responsible for checking these sites for any addendums or notices regarding this RFP.

7.12 Supplemental Information

The following web links are provided for informational purposes and may be referenced at the Offeror's discretion. The following items are available on-line:

- Virginia Medical Assistance Provider Manuals
  http://www.dmas.virginia.gov/prm-provider_manuals.htm
- Virginia Administrative Code Title 12VAC30120 sections 270-420 (MEDALLION and Medallion II program regulations
  http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR
- General Information - Section 1915(b) Waiver
  http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI
- Title 42 CFR Section 438 (Managed Care)
  http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfrv4_07.html
- Statistical Record of the Managed Care Program
  http://www.dmas.virginia.gov/ab-2005_stats.htm
- Medicaid Handbook http://www.dmas.virginia.gov/downloads/pdfs/rcp-medicaid_applicant_handbook_2007.pdf
- Medallion II Contract http://www.dmas.virginia.gov/downloads/pdfs/mc-07-01-06_Medallion_II_Contract.pdf
- HIPAA Final Rules and Standards
  http://aspe.hhs.gov/admnsimp/Index.htm
- Description of Home and Community-Based Waivers
  http://www.dmas.virginia.gov/ltc-home.htm#Waiver_Services_Program_
- Managed Care Website and Links to MCO websites
  www.virginiamanagedcare.com

8. PROPOSAL EVALUATIONS AND AWARD CRITERIA

Deleted: <#>Integration of Acute and Long Term Care ¶
http://www.dmas.virginia.gov/altc-home.htm ¶

The Department will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the

review and scoring of all proposals. This group will be responsible for the recommendation to the Department Director.

8.1 Evaluation of Minimum Requirements

The Department will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall result in a lower scoring of the proposal. The Department reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet: This form shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 8.9, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in Sections 3 and 4 and the Technical and Cost Proposal requirements described in Section 8.

Mandatory Conditions: All mandatory General and Special Terms and Conditions contained in Sections 9 and 10 shall be accepted.

Small Business Utilization – Summarize the planned utilization of DMBE certified small businesses and small businesses owned by women and minorities under the contract to be awarded as a result of this solicitation. (Attachment II).

8.2 Proposal Evaluation Criteria

The broad criteria for evaluating proposals include, but are not limited to, the elements below:

1. **Experience and Quality of References – 20%**
   Describe the experience, including length of time of the Offeror in performing Enrollment Broker and education services. Include the Offeror's experience in working with indigent populations, particularly Medicaid or other healthcare populations, as well as experience in performing services within the past year(s) most comparable to the Offeror's proposal (include a description of the type, size, and duration of previous experience).

   Provide references that support the Offeror's experience and abilities with respect to this contract. In addition, references should clearly address the nature of the work performed by the Offeror and should reflect the level of satisfaction with the Offeror's work performance. The Contractor may also include contacts for other contracts that exhibit satisfaction with the work performed by the Offeror.

2. Requirements and Technical Proposal and Staffing – 35%

Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services as described in Sections 3 and 4 of this RFP in a timely, efficient and professional manner. Describe the experience and expertise of specific staff assigned to the contract, including prior experience of staff with similar projects, qualifications of staff, appropriateness of the relationship between staff qualifications and assigned responsibilities.

3. SWAM Planned Utilization – 20% (see ATTACHMENT II)

4. Cost – 25%

The cost proposal shall be evaluated taking into consideration the fixed fee cost proposal shown in Attachments III a - c.

The cost proposal shall be evaluated and weighted but is not the sole deciding factor for the RFP. The lowest cost proposal shall be scored the maximum number of evaluation points for cost. All other cost proposals shall be evaluated and assigned points for cost in relation to the lowest cost proposal. Although cost proposals are evaluated and weighted, they are not the sole deciding factor for the RFP.

8.3 Oral Presentations

Oral presentations may be conducted with each Offeror to clarify proposal points. See §7.10.

8.4 Contract Award

Selection shall be made of two Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price. Negotiations shall be conducted with the Offerors so selected. Price shall be considered, but need not be the sole determining factor.

The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous *(Code of Virginia,* § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated

At the conclusion of negotiations, the Offeror(s) may be asked to submit in writing, a Best and Final Offer (BAFO). After the BAFO is submitted, no further negotiations shall be conducted with the Offeror(s). The Offeror's proposal will be rescored to combine and include the information contained in the BAFO. The decision to award will be based on the final evaluation including the BAFO. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror that, in its opinion, has made the best proposal, and shall award the contract to that Offeror.

The Department will conduct an on-site review to assess the readiness of the Offeror to effectively administer and provide the services as defined in this RFP.

At any time, the Department may terminate all activities and cancel or re-release this procurement. The reasons for such termination will be documented and made part of the State file.

8.5 Signing and Execution of the Contract

The successful Offeror will be required to enter into a contract with the Department within seven (7) days of having received a Final contract document from the Department. If the Offeror fails to enter into a contract within seven (7) days, the State may withdraw the notice and select another Offeror, restart the procurement, or discontinue the procurement entirely.

9. GENERAL TERMS AND CONDITIONS

9.1 Vendors Manual

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.State.va.us/dps under "Manuals."

9.2 Applicable Laws and Courts

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Department and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The Contractor shall comply with all applicable federal, State and local laws, rules and regulations.

9.3 Anti-Discrimination

By submitting their proposals, Offerors certify to the Commonwealth that they shall conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the

funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every contract over $10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

a) The Contractor shall not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by State law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, shall state that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor shall include the provisions of 10.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

9.4 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

9.5 Immigration Reform and Control Act Of 1986

By submitting their proposals, Offerors certify that they do not and shall not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

9.6 Debarment Status

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, State or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

9.7 Antitrust

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

9.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

9.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Susan Offie, Contract Monitor no later than 2:00 pm on December 2, 2008. Any revisions to the solicitation will be made only by addendum issued by the buyer.

9.10 Payment

1. To Prime Contractor:

    a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the State contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
    b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
    c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public Department is being billed.
    d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
    e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon

determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve the Department of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia,* § 2.2-4363).

2. To Subcontractors:

a. A Contractor awarded a contract under this solicitation is hereby obligated:

(1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

1. To notify the Department and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

a. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as Stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a small business contracting plan is a condition to the award, shall deliver to the contracting Department or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business contracting plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the Department or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

9.11 Precedence of Terms

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST,

MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

9.12 Qualifications of Offerors

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

9.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

9.14 Assignment of Contract

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

9.15 Changes to the Contract

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed or are mandated by changes in Federal or State laws or regulations. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

    a) By mutual agreement between the parties in writing; or

    b) By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of

work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or

c) By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the dispute provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

9.16 Default

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

9.17 Insurance

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it shall have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor shall have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: $100,000.

3. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)
5. Professional Liability/Errors and Omission $1,000,000 per occurrence, $3,000,000 aggregate.

9.18 Announcement of Award

Upon the award or the announcement of the decision to award a contract over $50,000, as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA web site (www.eva.virginia.gov) for a minimum of 10 days.

9.19 Drug-Free Workplace

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a Statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

For the purposes of this section, *"drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

9.20 Nondiscrimination of Contractors

A Bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by State law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the State Department, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative facility.

9.21 eVA Business-To-Government Vendor Registration

The eVA Internet electronic procurement solution, web site portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

a. eVA Basic Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.

b. eVA Premium Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

c. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

d. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.

9.22 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

10. SPECIAL TERMS AND CONDITIONS

10.1 Access to Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide

adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor shall be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

10.2 Access To and Retention of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

10.2.1 Access to Records

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the final payment. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

10.3 Advertising

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to the Department will be used in product literature or advertising without prior written permission from the Department. The Contractor shall not state in any of its advertising or product

literature that the Commonwealth of Virginia or any Department or institution of the Commonwealth has purchased or uses its products or services without prior written permission from the Department. The Department must approve any advertising, marketing or press release connected with this contract.

10.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The Department, its authorized agents, and/or State auditors shall have full access to and the right to examine any of said materials during said period.

10.5 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination,
b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.
e. Failure of the Contractor to identify overpayments that exceed a minimum of twice the contract costs may result in termination of the contract.

The Contractor shall not terminate this contract in part.

Each of these conditions for contract termination is described in the following paragraphs.

10.5.1 Termination for Convenience

The Contractor may terminate this Contract with or without cause, upon (90) days prior written notice to the Department. In addition, the Contractor may terminate the contract by opting out of the renewal clause. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

10.5.2 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

10.5.3 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

10.5.4 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

10.5.5 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to enrollee notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that the Department determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid or FAMIS enrollees, the Department may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

10.6 Remedies for Violation, Breach, or Non-Performance of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

10.6.1 Procedure for Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the

Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

10.6.2 Remedies Available to the Department

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

10.7 Performance Bonds

The Contractor shall deliver to the Department purchasing office an executed performance bond, in a form acceptable to the Department, in the amount of one month of the estimated annual contract amount, with the Department as obligee. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by the Department.

10.8 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by the Department. The Department will provide adequate prior notice of at least 30 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, the Department shall make payments as described in Section 6.

Each invoice submitted by the Contractor shall be subject to the Department approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by the Department.

10.9 Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From:_____ _____

Name of Offeror Due Date /Time

_____ _____

Street or Box Number City, State, Zip Code

_____

RFP Number

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

10.10 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using Department or to failure of the using Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

10.11 Small Businesses Subcontracting and Evidence of Compliance

A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential offerors are required to submit a Small Business Subcontracting Plan (Attachment XI). Unless the offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of proposals. If small business subcontractors are used, the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

B. Each prime contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon

completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.

C. Each prime contractor who wins an award valued over $200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

10.12 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees

10.13 Renewal of Contract

This contract may be renewed by the Commonwealth upon written agreement of both parties for three successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration. Costs may be negotiated at the time of optional renewal periods.

10.14 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from the Department during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

10.15 HIPAA Compliance

The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996

(HIPAA) regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to the Department. The Contractor shall also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with the Department to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the DMAS Internet Site at http://www.dmas.virginia.gov/hpa-home.htm.

10.16 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

10.17 Independent Contractor

Any Contractor awarded a contract under this RFP shall be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of the Department.

10.18 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

10.19 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed Statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. The Department must be notified within 10 days of any change in ownership. Any change in ownership shall not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with the Department without the expressed written consent of the Department Director.

10.20 eVA Business-To-Government Contracts and Orders:

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

b. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
(i) DMBE-certified Small Businesses: 1%, Capped at $500 per order.
(ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at $1,500 per order.

The eVA transaction fee will be assessed approximately 30 days after each purchase order is issued. Any adjustments (increases/decreases) will be handled through eVA change orders.

Internet electronic procurement solution, website portal www.eva.virginia.gov , streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following:

If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

10.21 Compliance with Virginia Information Technology Accessibility Standard

The Contractor shall comply with all State laws and Regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. This accessibility standards are State law see § 2.2-3502 and § 2.2-3503 of The Code of Virginia. Since this is a State law and the regulations apply to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals, the Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to The Virginia Code as well as any subsequent revisions to the Virginia Information Technology Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at http://www.vita.virginia.gov/docs/websiteStandards.cfm

10.22 Award

Selection may be made of Offerors who are deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offeror(s) selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror which, in its opinion, has made the best proposal, and shall award the contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not

deemed to be the most advantageous (*Code of Virginia,* § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the Contractor's proposal as negotiated.

ATTACHMENT I - REFERENCES

RFP 2009-02 Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc):	
Contract Size (# of facilities served , # of participants served, etc):	
Amount Recovered:	
Contract Period:	
Number of Contractor staff assigned to contract:	
Any legal or adverse contractual actions against the Offeror related to the project:	
Annual Value of Contract:	

_____ _____

Signature of State Official Date

ATTACHMENT II - SMALL BUSINESS SUBCONTRACTING PLAN

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of $10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbe.virginia.gov (Customer Service).

Offeror Name: _____

Preparer Name: _____ Date: _____

Instructions

A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.

B. If you are not a DMBE-certified small business, complete Section B of this form. For the offeror to receive credit for the small business subcontracting plan evaluation criteria, the offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified

small business in this section. Points will be assigned based on each offeror's proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the offeror's total price.

Section A

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a (**check only one below**):

_____ Small Business

_____ Small and Women-owned Business

_____ Small and Minority-owned Business

Certification number:_____Certification Date:_____

Section B

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement

Small Business Name & Address **DMBE Certificate #**	**Status if Small Business is also: Women (W), Minority (M)**	**Contact Person, Telephone & Email**	**Type of Goods and/or Services**	**Planned Involvement During Initial Period of the Contract**	**Planned Contract Dollars During Initial Period of the Contract**
Totals $					

ATTACHMENT III(a) COST PROPOSAL –
Managed Care Services

Deleted: *Other Than VALTC*

RFP 2009-02 **Enrollment Broker Services**						
Direct Costs		**Year 1**	**Year 2**	**Year 3**		**TOTAL**
Labor (by Individual or staff category)						
Subtotal Labor						
Benefits						
Total Labor						
Rent						
Travel						
Depreciation						
Equipment						
Furniture						
Office Supplies						
Software						
Temporary Help						
Recruitment						
Postage/Delivery						
Telephone/Fax						
Parking						
Misc (detailed)						
Total Other Direct						
TOTAL						
***Charge Per 100 Calls** *For call volume in excess of 40% of the total call volume projected.*						

Note: General and Administrative (G&A) and other indirect costs must be included in the direct cost figures. (The Department will not consider G&A or other fees as a separate line item.)

The Contractor shall provide pricing based upon specifications provided in Sections 3 and 4 in proportion to the number of individuals served.

Deleted: *excluding the VALTC population*

*The Department shall only pay for calls answered by staff members and will not reimburse for overage calls unless call volume exceeds 40% of the anticipated volume. Call volume for MEDALLION and Medallion II programs that exceeds 40% of the total estimate would be eligible for additional reimbursement. The Offeror must include a reasonable charge (per 100 calls) for call volume in excess of more than 40% of the total call volume projected in the Offeror's proposal.

ATTACHMENT III(b) - COST PROPOSAL: ***Miscellaneous Services***

Deleted: *VALTC and*

RFP 2009-02 Enrollment Broker Services						
		Year 1	**Year 2**	**Year 3**		**TOTAL**
Misc Costs** *Proposed hourly rate charge for systems changes in excess of forty hours as described in Sections 3.31 and 6.*						

Deleted: **VALTC Services** ¶
As described in Sections 3 and 4, including recipient education, enrollment activities and member materials. Call volume not to exceed 9,000 calls per year.

Deleted: ***VALTC Charge Per 100 Calls** ¶
For call volume in excess of 9,000 per year.

Note: General and Administrative (G&A) and other indirect costs must be included in the direct cost figures. (The Department will not consider G&A or other fees as a separate line item.)

**The Contractor shall provide pricing based upon specifications provided in Sections 3 and 4 for all populations served, including MEDALLION, Medallion II,

Deleted: *For VALTC, the Department shall only pay for calls answered by staff members and will not reimburse for overage calls for VALTC unless call volume exceeds 9,000 calls per year. The Offeror must include a reasonable charge (per 100 calls) for call volume in excess of the 9,000 calls per year. ¶

Deleted: and VALTC

ATTACHMENT III(c) - COST PROPOSAL - ***Optional Enrollment Broker Services***

RFP 2009-02 Enrollment Broker Services						
		Year 1	**Year 2**	**Year 3**		**TOTAL**
EPSDT Services						
Toll-Free Call Center - Central Point of Contact for all EPSDT related communications						
EPSDT Education For All Enrollees (note: this is already a required service for all eligible MCO enrollees).						
TOTAL						
Enhanced Technology						
Interactive Website						
Web-Based Enrollment Submission/Processing						
Web-Based HSA Submissions/Processing						
IVR Automated Enrollment Activities						
Other (itemize separately)						
TOTAL						
HSAs and Referral						
HSAs for MEDALLION						
MEDALLION Referrals to DMAS DM Contractor Per HSA as appropriate						
Other (itemize separately)						
TOTAL						

Deleted: HSAs for VALTC

Deleted: **VALTC HSAs Posted to MCO Bulletin Board**

Note: General and Administrative (G&A) and other indirect costs must be included in the direct cost figures. (The Department will not consider G&A or other fees as a separate line item.)

Reference Section 3.40. At the Department's discretion, one or more of the *Optional Services* may be implemented during the duration of the contract resulting from RFP 2009-02.

All costs should be itemized. Submit additional sheets using this same format as needed.

ATTACHMENT IV – WEEKLY MANAGED CARE HELPLINE ACTIVITY

Current Weekly Managed Care Helpline Activity Summary Report September 2008		**Incoming Calls**	**Average Talk Time**	**Outgoing Calls**
Monday	9/1/2008			
Tuesday	9/2/2008	1327	239	131
Wednesday	9/3/2008	1100	279	27
Thursday	9/4/2008	835	272	43
Friday	9/5/2008	622	294	41
Week Total		3884	266	242
Monday	9/8/2008	877	242	122
Tuesday	9/9/2008	635	302	83
Wednesday	9/10/2008	625	296	46
Thursday	9/11/2008	465	296	12
Friday	9/12/2008	455	276	11
Week Total		3057	279	274
Monday	9/15/2008	764	283	37
Tuesday	9/16/2008	573	278	30
Wednesday	9/17/2008	572	293	29
Thursday	9/18/2008	556	286	19
Friday	9/19/2008	388	282	18
Week Total		2853	284	133
Monday	9/22/2008	575	301	21
Tuesday	9/23/2008	529	266	19
Wednesday	9/24/2008	442	264	16
Thursday	9/25/2008	402	259	26
Friday	9/26/2008	428	247	10
Week Total		2376	270	92
Monday	9/29/2008	826	241	77
Tuesday	9/30/2008	968	269	39
Week Total		1794	256	116
TOTAL		**13964**	**272**	**857**

Deleted: *VALTC or*

**Does not include EPSDT Calls*

ATTACHMENT V – QUARTERLY MANAGED CARE HELPLINE ACTIVITY SUMMARY REPORT

Month	Incoming Calls	Average Talk Time	Outgoing Calls
January	15,909	267	505
February	13,415	258	223
March	12,815	259	173
Jan - Mar	**42,139**	**261**	**901**
April	12,625	270	195
May	12,058	273	235
June	11,236	268	400
Apr - Jun	**35,919**	**270**	**830**
July	13,977	286	649
August	12,589	277	551
September	13,964	272	857
Jul - Sep	**40,530**	**278**	**2,057**
October			
November			
December			
Oct - Dec	**0**	**0**	**0**
Annual Total	**118,588**	**270**	**3,788**

**Does not include EPSDT Calls*

Deleted: *VALTC or*

ATTACHMENT VI – MONTHLY TYPES OF CALLS AND LANGUAGE LINE USAGE

Monthly Types of Calls September 2008		
Type of Call	Number of Entries	Percentage of Entries
Address Change	212	1.5%
Complaint	39	0.3%
Enrollment	3,674	25.2%
Exemption Request	8	0.1%
Fee For Service	711	4.9%
Fulfillment	62	0.4%
Good Cause	2	0.0%
Inquiry	4,535	31.1%
Language Transfer	194	1.3%
MCO Call	2,620	18.0%
Medicare Part D	0	0%
Provider	254	1.7%
Quick Call	894	6.1%
Verify Eligibility	1,380	9.5%
Total	14,585	100.0%

**Does not include EPSDT Calls*

Deleted: *VALTC or*

LANGUAGE LINE USAGE

The following represents the Language Line usage during September 2008. The Virginia Managed Care HelpLine received a total of 1,014 Spanish calls through the Spanish queue in addition to Spanish calls coming through the English line. Spanish calls accounted for approximately eight percent of the total calls answered. There were a total of 97 calls made to the Language Line in September. Below is a breakdown of each language, the number of calls, and percentage.

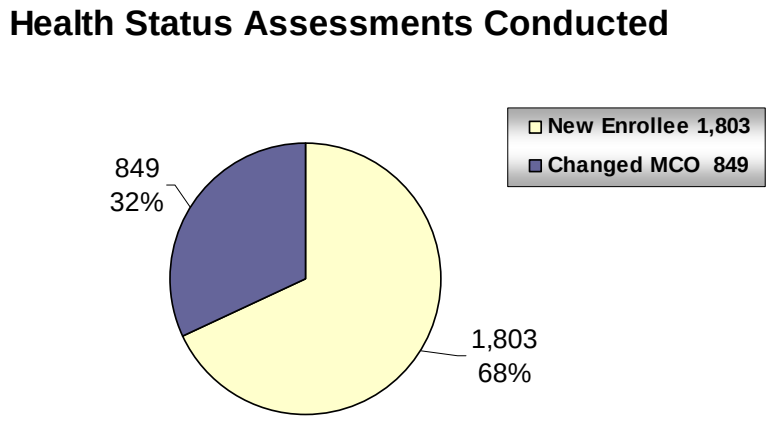
Language	Number of Calls	Percentage
Spanish	67	69.1%
Arabic	9	9.3%
Vietnamese	7	7.2%
Mandarin	5	5.2%
Amharic	3	3.1%
Farsi	2	2.1%
Korean	2	2.1%
Other	2	2.1%
Total	97	100.0%

**Does not include EPSDT Calls*

Deleted: *VALTC or*

ATTACHMENT VII – MONTHLY HEALTH STATUS ASSESSMENT TOTALS

The following represents the Health Status Assessment Report completed for September 2008 for the Medallion II population. There were a total of 2,652 Health Status Assessments completed for the month. There were 1,803 or 68 percent of HSAs for new enrollees and enrollees confirming MCO assignment. Thirty-two percent or 849 HSAs were conducted when clients transferred from one MCO to another.



ATTACHMENT VIII - HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private—only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head:	Case Head SSN:	Case Head Language:
Last Name	First Name	Medicaid ID#
Address	City	State/Zip Ph#

1	Gender	☐ Male ☐ Female
2	Date of Birth	
3	What MCO are you choosing?	Name:
4	Do you have a doctor you want to be your Primary Care Provider?	Name:
5	If you have a regular doctor now, what is the doctor's name?	Names:
6	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? [If yes] What are the names?	☐ Yes ☐ No List:
7	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]	☐ Yes ☐ No List:
8	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?	☐ Yes ☐ No What: ☐ Yes ☐ No
9	Are you pregnant? [If yes], ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy?	☐ Yes ☐ No Date:
	Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.	
10.	Do you have surgery planned for the future? If yes, what is the date of surgery?	☐ Yes ☐ No Date:
11.	Are you getting home care or home hospice care? If yes, please explain.	☐ Yes ☐ No Explanation:
12.	Are you on an organ transplant list? If yes, please explain.	☐ Yes ☐ No Explanation:

15.	Are you getting physical therapy, or occupational therapy, or speech therapy?	☐ Yes ☐ No
16.	Do you have a heart condition— such a congestive heart failure or coronary heart disease?	☐ Yes ☐ No List condition(s):
17.	Do you have a lung disorder—such as asthma or COPD?	☐ Yes ☐ No List condition(s):
18.	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐ No
19.	Do you have diabetes?	☐ Yes ☐ No
20.	High blood pressure?	☐ Yes ☐ No
21.	Do you have kidney disease or are you on dialysis?	☐ Yes ☐ No
22.	Do you have cancer?	☐ Yes ☐ No
23.	Do you smoke?	☐ Yes ☐ No
24.	Are you living with HIV or AIDS?	☐ Yes ☐ No
25.	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐ No
26.	Do you have tuberculosis (TB)?	☐ Yes ☐ No
27.	Is there a child in the house in ▪ Part C services, care coordination for children ▪ any health department program, or Does any child receive Case Manager or Care Coordinator services?	☐ Yes ☐ No List program and/or care coordinator:
28.	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐ No List:
29.	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐ No Reason:
30.	What is your height?	feet_____ inches_____
31.	And your weight?	Pounds
32.	Do we have permission to refer you to the Disease Management Program?	☐ Yes ☐ No If yes, add to list for HMC

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon. If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

ATTACHMENT IX – PROVIDER RECIPIENT ASSIGNMENT REQUEST

I. PROVIDER – RECIPIENT ASSIGNMENT REQUEST

Provider Name										
Provider Medicaid NPI Number										
Date: MM/DD/YY										

Please assign the following recipients to the above provider's panel:

RECIPIENT NAME	RECIPIENT MEDICAID ID NUMBER	DATE OF BIRTH
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Authorized Signature:

_____

II. Fax to: Managed Care Helpline 1-800-613-5955

ATTACHMENT X - MANAGED CARE OPEN ENROLLMENT EFFECTIVE DATE

CENTRAL VIRGINIA REGION LETTERS MAIL LATE JANUARY. RECIPIENTS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN, CULPEPER, AND WINCHESTER REGIONS LETTERS MAIL LATE JUNE. RECIPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1					
510	ALEXANDRIA	059	FAIRFAX CO.	683	MANASSAS CITY
013	ARLINGTON	610	FALLS CHURCH	685	MANASSAS PARK
047	CULPEPER	061	FAUQUIER	153	PRINCE WILLIAM
600	FAIRFAX CITY	107	LOUDOUN	139	PAGE
157	RAPPAHANNOCK	069	FREDERICK	043	CLARKE
171	SHENANDOAH	187	WARREN	840	WINCHESTER
NEAR SOUTHWEST AND WEST REGIONS LETTERS MAIL LATE AUG. RECIPIENTS CALL SEPT. AND OCT. CHANGES EFFECTIVE NOVEMBER 1					
003	ALBEMARLE	065	FLUVANNA	137	ORANGE
009	AMHERST	067	FRANKLIN CO.*	141	PATRICK*
011	APPOMATTOX	071	GILES*	143	PITTSYLVANIA
015	AUGUSTA	079	GREENE	155	PULASKI*
515	BEDFORD CITY*	083	HALIFAX	750	RADFORD*
019	BEDFORD CO.*	660	HARRISONBURG	770	ROANOKE CITY*
023	BOTETOURT*	089	HENRY*	161	ROANOKE CO.*
029	BUCKINGHAM	678	LEXINGTON*	163	ROCKBRIDGE*
530	BUENA VISTA*	109	LOUISA	165	ROCKINGHAM
031	CAMPBELL	680	LYNCHBURG	775	SALEM*
037	CHARLOTTE	113	MADISON	790	STAUNTON
540	CHARLOTTESVILLE	690	MARTINSVILLE*	820	WAYNESBORO
590	DANVILLE	121	MONTGOMERY*	197	WYTHE*
063	FLOYD*	125	NELSON		
MEDALLION LETTERS MAIL LATE NOV. RECIPIENTS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1					
005	ALLEGHANY	077	GRAYSON	191	WASHINGTON
017	BATH	091	HIGHLAND	195	WISE
021	BLAND	105	LEE	520	BRISTOL
027	BUCHANAN	167	RUSSELL	580	COVINGTON
035	CARROLL	169	SCOTT	640	GALAX
045	CRAIG	173	SMYTH	720	NORTON
051	DICKENSON	185	TAZEWELL		

ATTACHMENT XI - MEDALLION II EXCLUSIONS

(These exclusions are subject to change prior to the EB Contract begin date.)

In accordance with 12VAC30-120-370, the following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home- and community-based Medicaid coverage prior to managed care enrollment;
5. Individuals who are participating in foster care or subsidized adoption programs;
6. Individuals under age 21 who are enrolled in DMAS authorized residential treatment or treatment foster care programs;
7. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;
8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;
9. Individuals who receive hospice services in accordance with DMAS criteria;
10. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);
11. Individuals requesting exclusion who are inpatients in hospitals at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge;
12. Individuals who request exclusion during pre-assignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment who have been diagnosed with a terminal condition, and who have a life expectancy of six months or less. The client's physician must certify the life expectancy;
13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC §1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment;
14. Individuals who have an eligibility period that is less than three months;
15. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;
16. Individuals who have an eligibility period that is only retroactive; and
17. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

ATTACHMENT XII - MEDALLION EXCLUSIONS

In accordance with 12VAC30-120-280, the following individuals shall be excluded from participation in MEDALLION, or excluded from continued enrollment if any of the following apply:

a. Individuals who are inpatients in state mental hospitals and skilled nursing facilities, or reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a long-stay hospital;
b. Individuals who are enrolled in §1915c home and community-based waivers, the family planning waiver, or the Family Access to Medical Insurance Security Plan (FAMIS);
c. Individuals who are participating in foster care or subsidized adoption programs, who are members of spend-down cases, or who are refugees or who receive client medical management services;
d. Individuals receiving Medicare;
e. Individuals who are enrolled in DMAS-authorized residential treatment or treatment foster care programs;
f. Individuals whose coverage is retroactive only; and
g. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.
2. A client may be excluded from participating in MEDALLION if any of the following apply:
a. The client is not accepted to the caseload of any participating PCP.
b. The client's enrollment in the caseload of assigned PCP has been terminated, and other PCPs have declined to enroll the client.
c. The individual receives hospice services in accordance with DMAS criteria.

Deleted: **ATTACHMENT XIII - VALTC EXCLUSIONS**¶

(These exclusions are subject to change prior to the EB Contract begin date.)¶

¶

The MCO shall cover all VALTC Medicaid eligible individuals, with the exception of individuals excluded from the program in accordance with Federal and State regulations and DMAS guidelines. The Department shall exclude individuals who meet at least one of the exclusion criteria listed below.¶

¶

<#>Individuals in the pilot areas under age 21, including dual eligibles and those enrolled in EDCD Waiver services, remain excluded from VALTC at this time. ¶

Note: The only exception to the under age 21 rule is for babies born to a VALTC-enrolled participant who will be covered by the VALTC-MCO for the birth month plus two months (a total of 3 months maximum), or until transitioned to a Medallion II MCO (if applicable), or whichever occurs first. ¶

¶

b. Individuals who are inpatients in State mental hospitals. ¶

¶

<#>Individuals who are institutionalized (State Hospitals; ICF/MR facilities; Residential Treatment Facilities; long stay hospitals; existing nursing facility participants at the implementation of the VALTC program).¶

¶

<#>Individuals who are placed on spend-down.¶

¶

<#>Individuals who are participating in the family planning waiver, or in federal waiver programs for home-and-community-based Medicaid coverage (excluding EDCD).¶

¶

<#>Individuals who are participating in foster care or subsidized adoption programs.¶

¶

<#>Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician, midwife, or hospital) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid and the VALTC program.¶

¶

<#>Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals plac … [8]

ATTACHMENT XIV - MEDALLION II CARVED-OUT SERVICES

The following services are Medallion II carved-out services:

The Department shall cover community mental health rehabilitative services, emergency services (crisis), intensive outpatient, day treatment and SA case management services for Medicaid/FAMIS Plus enrollees. Transportation and pharmacy services necessary for the treatment of substance abuse services, including carved out services are the responsibility of the Contractor. Inpatient substance abuse treatment is not covered.

School health services. The Contractor shall not be required to cover school health services or services rendered in a nursing facility. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school.

Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with mental retardation; individuals with mental retardation and related conditions participating in home- and community-based care waivers; the elderly; and recipients of Auxiliary Grants as provided in 12 VAC §§ 30-50-420 through –470.

Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of eligible children who have been diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227.

Abortions as set forth in 12 VAC 30-50-180 and 42 C.F.R. § 441.203 and § 441.206.

Dental Services as set forth in 12 VAC 30-50-190.

Specialized infant formula and medical foods for individuals under age 21.

Private duty nursing (PDN) services when provided through HCBS waivers covered in 12VAC30-50-170, 12 VAC 30-120-10 through 30-120-259.

EPSDT Personal care services.

Services provided under the home and community-based Medicaid waivers (AIDS, Individual and Family Developmental Disabilities Supports, Mental Retardation, Elderly or Disabled with Consumer Direction, Day Support, or Alzheimers, or as may be amended from time to time) as set forth in 12VAC30-120-370. These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Deleted: **ATTACHMENT XV - VALTC CARVED-OUT SERVICES**¶

¶

¶

The following services are VALTC carved-out services:¶

¶

The Department shall cover community mental health rehabilitative services, emergency services (crisis), intensive outpatient, day treatment and SA case management services for Medicaid enrollees. Transportation and pharmacy services necessary for the treatment of substance abuse services, including carved out services are the responsibility of the Contractor. Inpatient substance abuse treatment is not covered. ¶

¶

Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with mental retardation; individuals with mental retardation and related conditions participating in home- and community-based care waivers; the elderly; and recipients of Auxiliary Grants as provided in 12 VAC §§ 30-50-420 through –470.¶

¶

Abortions as set forth in 12 VAC 30-50-180 and 42 C.F.R. § 441.203 and § 441.206.¶

¶

Dental Services as set forth in 12 VAC 30-50-190.¶

¶

Specialized infant formula and medical foods for individuals under age 21. ¶

¶

Certain transition and coordination services, specifically covered for an EDCD participant recently discharged from an institutional setting (nursing facility, or ICFMR) in following with the Department's *Money Follows the Person* program. ¶

¶

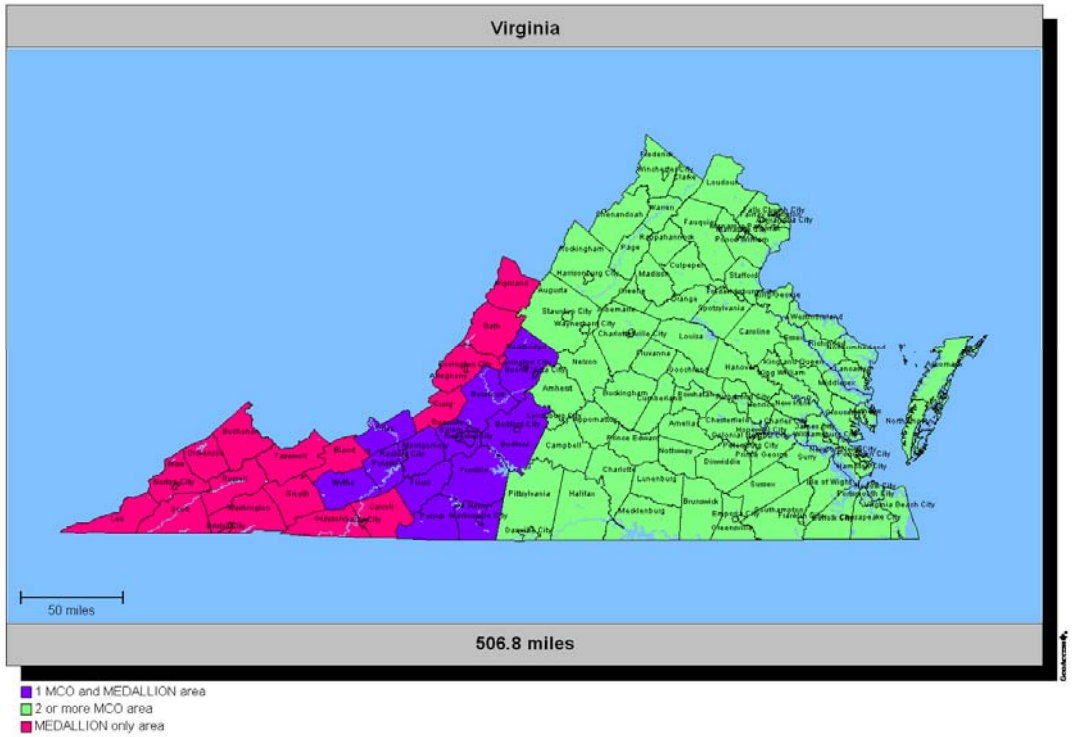
Up to sixty days of a nursing facility stay.¶

¶

ATTACHMENT XVI - MEDALLION AND MEDALLION II COVERAGE MAP

1

Geographic overview



ATTACHMENT XVII - MONTHLY VAMMIS EXTRACT FILE LAYOUTS

VAMMIS Monthly Recipient Extract File Format
(VAMMIS ID: RS-F-285)

```
01  EB-ENRL-RECORD.
    03 ENRL-ID-NAME.
       05 ENRL-ID                  PIC X(12).
       05 ENRL-NAME.
          07 ENRL-LNAME            PIC X(19).
          07 ENRL-FNAME            PIC X(12).
          07 ENRL-MIDINIT          PIC X(01).
          07 ENRL-SUFF             PIC X(03).
    03 ENRL-SSN                    PIC X(09).
    03 ENRL-DOB                    PIC X(08).
    03 ENRL-AID-CATG               PIC X(03).
    03 ENRL-I-CASE                 PIC X(12).
    03 FILLER                      PIC X(01).
```

VAMMIS Monthly Recipient Case Extract File Format
(VAMMIS ID: RS-F-280)

```
01  EB-CASE-RECORD.
    03 CASE-ID                     PIC 9(12).
    03 CASE-NAME.
          05 CASE-LNAME            PIC X(19).
          05 CASE-FNAME            PIC X(12).
          05 CASE-MIDINIT          PIC X(01).
          05 CASE-SUFF             PIC X(03).
    03 CASE-ADDRESS-INFO.
       05 CASE-ADDRESS.
          07 CASE-CONTACT          PIC X(40).
          07 CASE-STREET           PIC X(40).
          07 CASE-CITY             PIC X(17).
          07 CASE-STATE            PIC X(02).
          07 CASE-ZIP              PIC 9(09).
       05 CASE-FIPS                PIC X(03).
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DMAS will add the recipient program type (MEDALLION, Medallion II,) and VALTC

Deleted: and VALTC

ATTACHMENT XVIII – EPSDT BIRTHDAY CARD (ENGLISH VERSION)
(This post-card will soon be replaced by a newsletter; currently in development)

Dear Parent,

Give your child the best gift of all – a well-child check-up! Well-child check-ups are important because they provide your child with regular care as they grow. Check-ups can detect and prevent health problems. Best of all, well-child check-ups are free!

Please call your child's doctor to schedule a check-up and lead blood test today! I wish your family another year of health and happiness.

Sincerely,

Governor Timothy M. Kaine

ATTACHMENT XIX - EPSDT NEW MEMBER LETTER

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Dear Parent/Caregiver,

Welcome and Good News! Your child is now covered by the Medicaid or FAMIS Plus health insurance program. You can get free health care benefits to help keep your child healthy through a special program called EPSDT, which stands for Early, and Periodic Screening, Diagnosis and Treatment Program. It is very important because it provides your child with regular care as they grow up. There is no cost to you for these services.

EPSDT services are free and include:

- Regular check-ups for children and teens
- Shots (immunizations)
- Dental care
- Vision and hearing testing
- Medical screenings for problems
- Transportation – can be arranged by calling 1-866-386-8331
- Medically necessary services your child may need to correct a problem or prevent it from getting worse such as nursing, medical equipment, or counseling.

To get these services, call your child's doctor to schedule a check-up. Check-ups help to keep your child healthy. Remember to talk with your child's doctor about any special health needs your child has.

Soon, you will be receiving a member handbook that will help you to understand your covered health care benefits under the program.

Children should get seven check-ups before they are two years old

- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months

Between ages two and six, children need a yearly check-up.

- 2 years
- 3 years
- 4 years
- 5 years
- 6 years

After age six, children should have a check-up every two years.

- 8 years
- 10 years
- 12 years
- 14 years
- 16 years
- 18 years
- 20 years

ATTACHMENT XX - EPSDT CURRENT MEMBER LETTER

Dear Parent/Caregiver,

Good News! This is a reminder that your child is covered by the Medicaid or FAMIS Plus health insurance program. You can get free health care benefits to help keep your child healthy through a special program called EPSDT, which stands for Early, and Periodic Screening, Diagnostic and Treatment Program. It is very important because it provides your child with regular care as they grow up. There is no cost to you for these services.

EPSDT services are free and include:

- Regular check-ups for children and teens
- Shots (immunizations)
- Dental care
- Vision and hearing testing
- Medical screenings for problems
- Transportation – can be arranged by calling 1-866-386-8331
- Medically necessary services your child may need to correct a problem or prevent it from getting worse such as nursing, medical equipment, or counseling.

To get these services, call your child's doctor to schedule a check-up. Check-ups help to keep your child healthy. Remember to talk with your child's doctor about any special health care needs your child has.

Children should get seven check-ups before they are two years old

- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months

Between ages two and six, children need a yearly check-up.

- 2 years
- 3 years
- 4 years
- 5 years
- 6 years

After age six, children should have a check-up every two years.

- 8 years
- 10 years
- 12 years
- 14 years
- 16 years
- 18 years
- 20 years

ATTACHMENT XXI - EPSDT LEAD LETTER

XX Date XX

Re: «Child_First_Name» «Child_Last_Name»

Dear «ParentGuardian» Family:

The Virginia Department of Medical Assistance Services and the Virginia Department of Health would like to remind you about the importance of blood lead testing for children. Elevated blood lead levels affect an estimated 13,800 children under age six in Virginia. We are concerned because lead interferes with normal brain development and is associated with permanently reduced IQ, learning disabilities and behavioral disorders. The primary source of elevated blood lead levels is dust from lead-based paint in many of Virginia's 1.8 million homes built before 1978.

Your child has recently received a lead screening test and this test needs to be repeated to check for an elevated blood lead level. Blood lead screening may be obtained from you child's physician or your local health department. Please contact your child's health care provider immediately to set up an appointment. Once your child has received a blood lead test, it is important to follow-up with your physician for lab results and patient education. Enclosed is a pamphlet, which explains how to prevent, detect, and treat lead poisoning.

If you have any questions about environmental lead testing for your child please contact Lead Safe Virginia toll free at 1-877-668-7987.

Lead-Safe Virginia Program
Call toll free (877) 668-7987
FAX (804) 864-7722
E-mail: leadsafe@vdh.virginia.gov

Truly yours,

Tammy Whitlock, Manager
Maternal and Child Health Services
Department of Medical Assistance Services

Deleted: **ATTACHMENT XXII - VALTC LOCALITIES AND SPECIFIC SERVICES**¶

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VALTC will be initially offered in the Tidewater area beginning July 1, 2009. For the Tidewater launch, prospective managed care organizations (MCOs) will contract for all targeted populations in the core localities. MCOs may include the provision of services for any or all of the non-core localities. DMAS, however, must have a minimum of two MCOs in each locality in order to implement the program. VALTC covered localities for Tidewater are as follows:¶

¶

Tidewater (July 1, 2009) ¶

FIPS

... [9]

ATTACHMENT XXIII - SUMMARY OF MEDICAID/FAMIS PLUS SERVICES

The Medicaid program covers services for all eligible recipients, including, but not limited to:

- Inpatient hospital care
- Outpatient hospital care
- Physician's services
- Outpatient psychiatric and psychological services
- Prescription drugs
- Home health services
- Clinic services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children under age 21
- Podiatry
- Dental care and orthodontia care for children up to age 21
- Family-planning services
- Emergency and non-emergency medical transportation
- Hospital emergency room
- Post Stabilization Care following Emergency Services
- Medical supplies and equipment
- Nursing facility care
- Rehabilitation services
- Prosthetic devices
- Orthotic devices for children up to age 21
- Hearing aide devices for children up to age 21
- Baby care services
- Immunizations
- Maternal and infant care coordination
- Expanded prenatal services
- Women's Health Care (pap smears, mammography, etc.)
- Prostate specific antigen (PSA) testing
- Hospice services
- Community mental health, and mental retardation services
- Organ transplantations
- Court ordered/ temporary detention ordered (TDO) services
- School based services
- Routine eye examinations (limit 1 every 2 years)
- Eyeglasses for recipients under age 21
- Outpatient Substance Abuse Treatment
- Colorectal Cancer Screening
- Laboratory and X-ray services
- Physical and occupational Therapy
- Speech Pathology and Audiology services
- Reconstructive breast surgery

Exclusions from Medicaid covered services may include, but are not limited to: routine dental for recipients age 21 years and over, eyeglasses for recipients age 21 years and over, routine physicals and immunizations for recipients age 21 years and over; abortions unless the pregnancy is life-or health-threatening to the mother; sterilizations for recipients under 21 years of age; experimental surgical and diagnostic procedures; and inpatient hospital care in an institution for the treatment of mental disease for recipients older than 20 and younger than 65 years of age.

ATTACHMENT XXIV –ENROLLMENT MATERIALS - VOLUMES AND COST

Enrollment Materials Mailed By Month - February 2008 – September 2008

Items	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08
Charts	10,123	10,949	69,410	9,871	59,151	10,472	67,170	12,395
PCP Brochures	1,374	1,583	1,430	1,231	1,208	1,290	1,426	1,545
MCO Brochures	10,123	10,949	11,696	9,871	10,475	10,472	11,004	12,395

Annual Enrollment Materials – Contract Year 2007 – 2008

Items	Quantity	Cost
Charts	413,800	$34,256
PCP Brochures	16,000	$1,199
MCO Brochures	151,000	$8,173
Total	580,800	$43,628

ATTACHMENT XXV - ASSURANCES OF FEDERAL REGULATORY COMPLAIANCE

This attachment addresses Federal regulations for:

- Requiring freedom from conflict of interest;
- For the handling of specific enrollment broker activities; and,
- Requiring avoidance of conflict of interest.

The Enrollment Broker (EB) shall observe and comply with all Federal and State laws collected from the Code of Federal Regulations (CFR), the State Medicaid Manual (SMM), State Medicaid Letters (SMD) and the Social Security Act (SSA) which contain provisions enacted by the Balanced Budget Act (BBA) of 1997. This compliance is effective when the EB Contract is signed or which may come into effect during the term of the EB Contract. In case of contract disputes, these documents will be reviewed and considered in the order shown to resolve said disputes:

a. Federal Regulations
b. Virginia State Plan
c. Managed Care 1915 (b) Waiver
d. Medallion II and MEDALLION State Regulations
e. Enrollment Broker Contract, including RFP, RFP amendments, EB Contractor Proposal, attachments, and Medicaid memos and manuals.

FEDERAL REGULATORY REQUIREMENTS (CMS Checklist for EB Contract Approval)

1. Independence (Reference SSA 1903(b)(4)(A); 42 CFR 438.810(a))

The Enrollment Broker and/or its subcontractors must be independent from any DMAS contracted managed care organizations (MCO) and health care provider that provides coverage in the same state in which the enrollment broker is conducting enrollment activities.

An Enrollment Broker or its subcontractor is not considered ‘‘independent’’ if it:

- Is an MCO, PCCM or other health care provider in the State;
- Is owned or controlled by an MCO, PCCM, or other health care provider in the State; or
- Owns or controls an MCO, PCCM or other health care provider in the State.

2. Freedom from Conflict of Interest (Reference SSA 1903(b)(4)(B); 42 CFR 438.810(b)

The Enrollment Broker or its subcontractor is **not** considered free from conflict of interest if any person who is the owner, employee, consultant or subcontractor has:

- Any direct or indirect financial interest in any MCO or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;
- Been excluded from participation under Title XVIII or XIX of the Act;
- Been debarred by any Federal agency; or
- Been, or is now, subject to civil money penalties under the Act.

3. Conflict of Interest Safeguards (Reference SSA 1932(d)(3); 42 CFR 438.58(a) and (b)

The Department administers the default enrollment process in accordance with the 42 CFR 438. The Enrollment Broker is not responsible for the default process.

4. Enrollment Discrimination Prohibited (Reference SSA 1903(m)(2)(A)(v); 42 CFR 438.6(d)(1),(3) and (4); SMM 2090.4)

The Enrollment Broker must provide choice counseling and enrollment activities that does not promote enrollment discrimination, such as:

- MCO or PCCMs must accept individuals in the order in which they apply without restriction, (unless authorized by the Regional Administrator), up to the limits set under their contract.
- The Enrollment Broker will not discriminate against individuals eligible to be covered under contract on the basis of health status or need for health services.
- The Enrollment Broker will not allow the MCO or PCCM entity to discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

5. Compliance with Contracting Rules (Reference 42 CFR 438.6(f) (1))

The Enrollment Broker must comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

6. Enrollment Broker Contract Functions (Reference CFR 438.810(a); 45 CFR 74.43 and 74.44; SMM 2080.6; SMM 2080.3; SMM 2080.5; SMM 2080.4; SMM 2080.10; SMM 2080.11)

The Enrollment Broker shall adhere to the full scope of requirements described in Section 3 which includes:

- A clear and accurate description of the technical requirements for the material, product, or service to be performed.
- Contracts will be in writing.
- The population covered.
- Nonperformance, payment, and other sensitive issues.
- The contract period, procedures and criteria for extending the contract.
- Renegotiation procedures and criteria.

7. Terminology (Reference 42 CFR 438.10(a)

The Enrollment Broker shall strictly adhere to the Federal definition standards for enrollee, potential enrollee, Enrollment Broker, enrollment services, choice counseling, and enrollment activities, as stated in Section 1.

8. Information – Format Requirements (Reference SSA 1932(a)(5)(A); 42 CFR 438.10(d)(1)(i); 42 CFR.438.10 (b)(1), SMD letter 02/20/08)

All enrollment notices, informational and instructional materials shall be available upon request and prepared in a way that is easily understood by enrollees and potential enrollees. Written material must be in an easily understood language and format.

9. Information – Language Requirements (Reference 42 CFR 438.10(c) (3), 42 CFR 438.10(c)(5) (i);42 CFR 438.10(c)(4)

In accordance with Section 3, the Enrollment Broker must make written information available in Spanish. The Enrollment Broker must make oral interpretation services available free of charge to each enrollee and potential enrollee.

The Enrollment Broker must notify its enrollees:

- that oral interpretation is available for any language,
- that written information is available in Spanish, and
- how to access the interpretation services and written information.

10. Information – Alternative Formats [Reference 42 CFR 438.10(d)(1)(ii) and (d)(2]

Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

11. Information – Potential Enrollees and Enrollees Non-Covered Services (Reference SSA 1932(a)(5)(D); 42 CFR 438.10(e) and (f); SMM 2088.8; SMM 2092.9)

The Contractor must ensure that each managed care enrollee or potential enrollee is informed of services available under the State Plan. The Department or MCO, where applicable, shall inform the enrollee of covered benefits including how they may be accessed.

12. Information – Potential Enrollees (Reference 42 CFR 438.10(e)(1) and (e)(2); 42 CFR 438.102(c)

In following with the Department CMS 1915(b) waiver, the Department shall:

- Inform potential enrollees of their mandatory enrollment into managed care;
- Provide potential enrollees with a comparison chart of the MCOs or listing of PCCM providers in their area;
- Provide basic information on managed care; and,
- Provide timeframe to call the enrollment broker to make their managed care provider selection.

As required in Section 3, the Enrollment Broker shall inform enrollees:

- Of basic features of managed care;

- Which populations are excluded from enrollment or subject to mandatory enrollment;
- Of MCO and PCCM responsibilities for coordination of enrollee care;
- With information specific to each MCO or PCCM program operating in potential enrollee's service area;
- Of benefits covered;
- Of service area; and,
- Of names, locations, telephone numbers of current contracted primary care providers.

13. Information – Enrollees (Reference 42 CFR 422.208; 42 CFR 422.210; 42 CFR 431.230; 42 CFR 438.10(f); 42 CFR 438.10(f)(2); 42 CFR 438.10(f)(3); 42 CFR 438.10(f)(6); SMD Letter 01/21/98; 42 CFR 438.10(f)(6)(iv); 42 CFR 438.10(g)(1); 42 CFR 438.10(h); 42 CFR 438.102(c); 42 CFR 438.400 through 424; 42 CFR 438.6(h); 42 CFR 438.6(i)(1); 42 CFR 438.6(i)(2); 42 CFR 489.102(a); SMM 2900; SMM 2902.2)

The Department administers the function of notifying enrollees of rights (for changing from one MCO to another), including the right to change during the first 90 days of enrollment without cause, during open enrollment, outside of the first 90 days with good cause, and outside of open enrollment with good cause. The Enrollment Broker shall address inquiries regarding these rights from enrollees or potential enrollees.
The Enrollment Broker shall respond to questions regarding provider participation requirements as addressed in Section 3. Otherwise, the Enrollment Broker shall refer to the Department or the MCO (as appropriate) requests for detailed information regarding: names, locations, and telephone numbers of participating specialty providers accepting new patients, non-English languages spoken by current contracted providers (MCO); MCO program rules e.g., referrals and service authorizations (MCO); enrollee rights and protections (MCO Member handbook); grievance and appeals processes (MCO Member Handbook and Medicaid Handbook); amount, duration, and scope of benefit coverage (MCO Member handbook); how to obtain benefits that are covered under the MCO contract (MCO Member Handbook); how to obtain benefits that are carved out of the MCO contract (MCO Member Handbook/DMAS Helpline); how to access emergency and post-stabilization services (MCO Member Handbook); cost sharing responsibility under the MCO (MCO Member ID Card); and other information not available to the Enrollment Broker that is available from the MCO or the Department directly and upon request. DMAS or the appropriate MCO shall respond to the enrollee directly.

14. Information – Informing Enrollees of Rights (Reference 42 CFR 438.10(f)(3); 42 CFR 438.100(b)(2)(ii); 42 CFR 438.100(c)

The Department administers and does not delegate the function of informing enrollees of rights as referenced in the Federal regulations cited above.

15. Choice Counseling – Mechanism (Reference 42 CFR 438.10(b) (2)

The Enrollment Broker shall have a mechanism in place to help enrollees and potential enrollees understand the basic principles of the Department's managed care programs,

and to provide choice counseling to assist enrollees in making a MCO and/or PCCM provider selection in accordance with Section 3. Also see # 12 above.

16. Enrollment – Process (Reference 42 CFR 434.6 (a) (3); SMM 2080.7)

The Enrollment Broker must adhere to Sections 2 and 3 which specifies enrollment and re-enrollment procedures for the covered populations, including a description of the processes handled by the Department and those that are required by the Enrollment Broker.

17. Enrollment – Voluntary unless 1932 SPA or a Waiver Program (Reference 42 CFR 438.6 (d) (2)

Enrollment in the MEDALLION, Medallion II, MCO programs is mandatory as approved in the CMS 1915 (b) Waiver and as described in this RFP.

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18. Enrollment – Automatic Reenrollment (Reference 42 CFR 438.56(c) (2) (iii); 42 CFR 438.56 (g); SMM 2090.5)

The automatic re-enrollment process is administered by the Department as described in Section 3.9. The Enrollment Broker contract is amended to grant the recipient the right to request disenrollment upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

19. Enrollment Activities – Limitations on Enrollment 1932 SPA States (Reference SSA 1932(a)(2); 42 CFR 438.50 (d))

20. Enrollment Activity – Priority for Enrollment in 1932 SPA (Reference 42 CFR 438.50 (e).

21. Enrollment Activity – Enrollment by Default in 1932 SPA (Reference 42 CFR 438.50 (f).

22. Information – Comparison information for 1932 SPA (Reference 42 CFR 438.10(i)

The four requirements (19-22) above are not applicable as the Department's Managed Care programs operate under the approval of a CMS 1915 (b) Waiver [not under a State Plan Amendment (SPA)].

23. Choice of Health Professional (Reference 42 CFR 438.6(m);SMM 2090.2)

In accordance with Section 3, the Enrollment Broker is required to assist the enrollee with the selection of a participating MCO by providing the names of primary care providers participating with the MCOs. The Enrollment Broker shall refer the enrollee or potential enrollee to the MCO for PCP selection.

24. Enrollment Activity – Limitations on Changes Between Primary Care Providers (Reference 42 CFR 438.52(d); 42 CFR 438.56(c) Regulation Correction 10/25/02; SMD Letter 01/14/98)

In accordance with Section 3, the Enrollment Broker is required to assist the enrollee with the selection of a participating MCO by providing the names of primary care

providers participating with the MCOs. The Enrollment Broker shall refer the enrollee or potential enrollee to the MCO for PCP selection.

25. Disenrollment – Functions (Reference 42 CFR 438.56(d)(3)(i) and (ii)

In accordance with Section 3, the Enrollment Broker is responsible for processing all disenrollment requests that are made by enrollees (orally or in writing) within the established timeframes. Any enrollee disenrollment requests received outside of the established timeframes shall be referred by the Enrollment Broker to the Department for handling under the good-cause for disenrollment process/rules.

26. Disenrollment – Use of Entity's Grievance Procedures (Reference 42 CFR 438.56(d)(5)(ii) and (iii); 42 CFR 438.56(e)(1)

The Department administers the grievance system for all disenrollment related activities through the State Fair Hearing process. The Enrollment Broker is not allowed to make these determinations.

27. Disenrollment – Annual Open Enrollment Period (Reference SSA 1932 (a) (4) (A); 42 CFR 438.56(c)(2)(ii); SMD Letter 01/21/08; SMM 2090.3)

The Department notifies all managed care participants of their open enrollment period at least once every 12 months. The Enrollment Broker is responsible to make disenrollment changes for enrollees as described in Section 3. Also refer to #18 above for disenrollment changes allowed where the enrollee has missed open enrollment during the auto-re-enrollment process.

28. Disenrollment – During Intermediate Sanctions (Reference SSA 1932 (e)(2)(C); 42 CFR 438.56(c)(iv); 42 CFR 438.702(a)(3); SMD Letter 02/20/08)

The Enrollment Broker shall honor any request by an enrollee to disenroll from any sanctioned MCO to another participating health plan in situations where the Department has imposed an intermediate sanction on a MCO that freezes or limits MCO enrollment.

29. Disenrollment – Requests (Reference 42 CFR 438.56(d)(1)(i) and (ii)

In accordance with Section 3, the Enrollment Broker is responsible for processing all disenrollment requests that are made by enrollees (orally or in writing) within the established timeframes. Any enrollee disenrollment requests received outside of the established timeframes shall be referred by the Enrollment Broker to the Department for handling under the good-cause for disenrollment process/rules.

30. Disenrollment – Cause (Reference 42 CFR 438.56(d)(2)

The Department administers the function of reviewing requests for disenrollment under good-cause guidelines in accordance with 42 CFR 438.56, including the specific bullet points listed below. The Enrollment Broker is responsible for advising members who call the Managed Care Helpline about the process in which they can request good cause;

taking the request for good cause orally or in writing; and submitting the recipient's request for good-cause disenrollment to DMAS for review and response.

Per 42 CFR 438.56(d)(2), the following requirements are cause for disenrollment:

- The enrollee moves out of the MCO's or PCCM's service area.
- The plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

31. Disenrollment – Timeframes (Reference 42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(4); SMM 2090.6; SMM 2090.11)

The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for good-cause in accordance with 42 CFR 438.56. Per 42 CFR 438.56(e)(1) and (2); 42 CFR 438.56(d)(4); SMM 2090.6; SMM 2090.11 regardless of the procedures followed, the effective date of an approved disenrollment will be no later than the first day of the second month following the month in which the request was filed. If the Department fails to make the determination within these timeframes, the disenrollment is considered approved.

32. Disenrollment – Denial Notice and Appeals (Reference 42 CFR 438.56(f)

- The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for disenrollment under good-cause guidelines in accordance with 42 CFR 438.56(f). The Department responds to requests for disenrollment in writing and the response includes the recipient's right to a State Fair Hearing for any enrollee dissatisfied with the Department's determination that there is not good cause for disenrollment. Additionally, enrollees receive an annual notice 60 days prior to their enrollment date notifying them of open enrollment.

33. Disenrollment – Reasons for Disenrollment (Reference SSA 1903(m)(2)(A)(v); SSA 1932(a)(4)(A) and (B); 42 CFR 456(c); 42 CFR 438.56(c)(1); 42 CFR 438.56(b)(1),(2) and (3); SMD Letter 01/21/98; SMM 2090.6 through 9; SMM 2090.4; SMM 2090.12; SMM 2088.3; SMM 2080.7)

The Department administers (does not delegate to the Enrollment Broker) the function of reviewing requests for disenrollment requests submitted by the MCO or PCCM. The Department's processes are in accordance with the bulleted requirements listed below.

The Enrollment Broker is responsible for conducting enrollment activities other than those that fall under "good-cause." The Enrollment Broker shall refer any requests for

good cause disenrollment or any requests for disenrollment received from the MCO or PCCM to the Department for review and response.

The Enrollment Broker shall honor requests for disenrollment (change from one health plan to another) outside of the annual open enrollment in circumstances where the recipient's temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

The Department handles requests for disenrollment received from the MCO in accordance with the Medallion II Contract, which sites the reasons for which the MCO may request disenrollment of an enrollee.

Under the Managed Care 1915(b) Managed Care Waiver, Virginia chooses to limit disenrollment, but provides that a recipient may request disenrollment as follows:

- For cause, at any time.
- Without cause, at the following times:
    - During the 90 days following the date of the recipient's initial enrollment with the MCO or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.
    - At least once every 12 months thereafter (open enrollment).
    - Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
- When the State imposes the intermediate sanction specified in § 438.702(a)(3).

34. Enrollees with Special Health Care Needs Assessment (Reference 42 CFR 438.208(c)(2)

This function is not delegated to the Enrollment Broker.

The Department's MCO Contracts require that the MCO implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

35. Language (Reference 42 CFR 438.10(c)(1)

The Department administers (does not delegate to the Enrollment Broker) the function for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. ''Prevalent'' means a non-English language spoken by a significant number or percentage of enrollees and potential enrollees in the State.

36. Race, Ethnicity, and Primary Language Identification (Reference 42 CFR 438.204(b)(2)

The Department administers (does not delegate to the Enrollment Broker) the function for identifying the race, ethnicity, and primary language spoken of each Medicaid enrollee. The Department provides this information to the MCO for each Medicaid enrollee at the time of enrollment.

37. In accordance with 42 CFR 438.56 and 42CFR 438-810, the Enrollment Broker (Contractor) Shall adhere to all of the following *"Avoidance of Conflicts of Interest Requirements."* (SMD Letter dated 9/11/2008)

A. The Department intends to avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DMAS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to the Department's review and prior approval.

B. Conflicts of interest include, but are not limited to:

1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use of disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the Contract.

2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

C. If the Department is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) business days from the date of notification of the conflict by the Department to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by the Department and cannot be resolved to the satisfaction of the Department, the conflict will be grounds for terminating the Contract. The Department may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

D. The Contractor shall submit for the Department's review and approval, a *"Conflict of Interest Disclosure Statement"* (Disclosure Statement), a *"Conflict of Interest Disclosure Statement Questionnaire"* (Questionnaire) and, as necessary, a *"Conflict of Interest Disclosure Avoidance Plan"* (Avoidance Plan), using the following timetable:

1. Originals two (2) weeks after Contract Effective Date (CED);
2. An update January 1st of each calendar year thereafter;
3. The originals completed by new Program personnel within ten (10) business days of their hire; and,
4. An update completed by Program personnel who experience a change in holdings that may create a real or apparent conflict of interest within ten (10) business days of such change.

The Disclosure Statement shall fully describe any direct or indirect interest the Contractor, any part or any subcontractor, has in any MCO, PIHP, PAHP, PCCM or other health care provider in Virginia Medicaid (as defined in Title 42, CFR, Subpart 438.810), together with the name and position description of the Contractor, any parent, or subcontractor employee, director, consultant, or officer about whom the disclosure is being made.

At a minimum, the Contractor's Disclosure Statement shall disclose the name and address of any and all MCO, PIHP, PAHP, PCCM or other health care provider in Virginia Medicaid in which:

a. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employee, director, consultant, or officer has a direct or indirect interest of any dollar amount.
b. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's or any parent corporation's or any subcontractor's employees, directors, consultants, or officers assigned to the Contract is a director, officer, partner, trustee, employee, or holder of a management position, or is self-employed; and,
c. The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employees, directors, consultants, or officers assigned to the Contract, has derived any direct or indirect income within the twelve (12) months immediately prior to the submittal of a proposal.

Questionnaires shall be completed by all Contractor program personnel, and, of those with real or apparent conflict of interests, Avoidance Plans shall be completed. The Contractor shall provide copies of all Questionnaires, and as necessary, all Avoidance Plans, to the Department using the timetable described above.

The Contractor shall disclose the name of any proposed subcontractor, consultant, officer, director, or employee who was employed by the State of Virginia, the Department of Medical Assistance of Services, the Governor's Office, the Department of Health, State Controller's Office, Office of the Attorney General, and/or the Legislature as of January 2008.

If a real or apparent conflict exists, the Contractor shall, together with the Disclosure Statement and Questionnaire, submit an Avoidance Plan and procedures to hold separate such relationships and/or to safeguard against conflicts. If the Contractor has nothing to disclose under this section, it shall so certify in its Disclosure Statement.

The Contractor shall furnish to the Department the ownership and control information required by Title 42, CFR, Subpart 438.810 prior to the Contract Effective Date.

The Contractor's Representative, or the selected designee, shall certify under penalty of perjury that such reports and updates to such reports are accurate, complete and current to the best of that individual's knowledge and belief unless the requirements is expressly waived by the Contracting Officer in writing.

The Avoidance Plan shall include procedures to:

a. Guard against conflict of interest;
b. Hold separate any disclosed relationships or any potential conflict of interest relationships that could arise during the life of the Contract, including but not limited to

such problematic matters as financial interactions, reporting, sharing of office space, staff interactions, or Contractor fulfillment of Contract responsibilities; and,

c. Ensure that the Contractor shall discharge its responsibilities and duties with disinterested skill, zeal, diligence, and that no Contractor's, parent corporation's, or subcontractor's employee, officer, director, or consultant will be in a position to exploit that position for private benefit or for other Contractor, or parent corporation or subcontractor interests which are or may be in conflict with the Department's interests.

ATTACHMENT XXVI MONTHLY MEDALLION PROVIDER FILE FORMAT

REG_NUM
REG_COD
REG
LOC
CTY
SPC_COD
SPC
PHY
FMT_IND
ACT
AD1
AD2
AD3
CIT
STA
BLK1
ZIP
DAS
EXT
PHO
APT_COD
SCD
NEW_COD
NEW_COD
REC_NO

**This is the format of the hard and electronic copy that is made available to the Enrollment Broker monthly through the Department's mailing vendor.*

ATTACHMENT XXVII MONTHLY MEDALLION II PROVIDER FILE FORMAT

Deleted: VALTC AND

Number	Data Element	Type	Size	Start	Stop
1	MCO Code*	numeric	10	1	10
2	Action Ind* (A=Active, D=Delete)	alpha	1	11	11
3	Clinic/PCP Ind* (P=PCP, C=Clinic)	alpha	1	12	12
4	Provider Number **	alpha	15	13	27
5	Program Code* (M2=Medallion II, OP=Options)	alpha	2	28	29
6	Provider Last Name*	alpha	30	30	59
7	Provider First Name*	alpha	30	60	89
8	Address Line 1	alpha	30	90	119
9	Address Line 2	alpha	30	120	149
10	City	alpha	30	150	179
11	Zip Code	numeric	9	180	188
12	Phone Area Code	numeric	3	189	191
13	Phone Number	numeric	7	192	198
14	Phone Extension	numeric	4	199	202
15	Office Hours	alpha	25	203	227
16	Specialty Code (see below)	alpha	1	228	228
17	Language 1 (see below)	alpha	2	229	230
18	Language 2	alpha	2	231	232
19	Language 3	alpha	2	233	234
20	Language 4	alpha	2	235	236
21	Language 5	alpha	2	237	238

* This filed must be included for every record in the file

Specialty Codes

C=Clinic
F=Family
G=General
I=Internist
O=OB/GYN
P=Pediatrics
X=Other

Languages

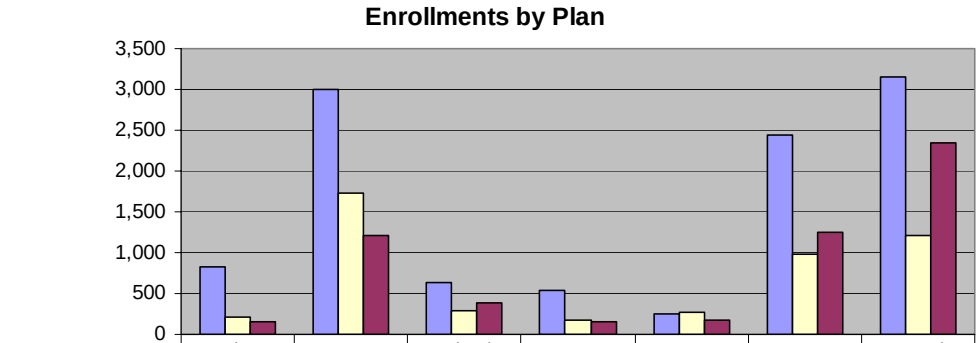
SP=Spanish
GR=German
FR=French
IT=Italian
RS=Russian

ATTACHMENT XXVIII – ENROLLMENT ACTIVITY

February1, 2007 through January 30, 2008

Enrollments by Plan represents enrollment activity for the MCOs. The chart shows the number of new enrollments, transfer enrollments, and open enrollment transfers for each MCO. The total number of enrollments the HelpLine conducted into MCOs during this reporting period was 21,369. New enrollments were 10,817, open enrollment transfers were 4,864, and transfer enrollments were 5,688.

In addition, MEDALLION enrollments totaled 13,910. There were 5,690 new enrollments, 2,656 transfers were made into MCOs or transferred to another PCP during open enrollment, and 5,564 were transfer enrollments. Included in the enrollment totals, MAXIMUS processed 4,640 panel form transactions. In total, the HelpLine conducted 35,279 enrollments during this reporting period.



	Amerigroup 1,203	Anthem 5,936	Peninsula 1,295	Priority 868	CareNet 676	Optima 4,678	VAPremier 6,713
New Enrollment	823	2,991	629	533	245	2,435	3,161
Open Enrollment	217	1,735	287	172	264	987	1,202
Transfer Enrollment	163	1,210	379	163	167	1,256	2,350

ATTACHMENT XXIX – MANAGED CARE ENROLLMENT CHANGES BY MONTH

Managed Care Enrollment Report
August 2008

Enrollments - This Month

FFS*			MEDALLION*			Medallion II*			Total
245,298			51,951			419,844			717,093
34%			7%			59%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
184,334	4,651	56,313	19,062	3,472	29,417	111,407	28,810	279,627	
75%	2%	23%	37%	7%	57%	27%	7%	67%	

Enrollments - Last Month

FFS*			MEDALLION*			Medallion II*			Total
242,587			52,173			420,207			714,967
34%			7%			59%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
183,670	4,451	54,466	19,131	3,492	29,550	110,685	28,796	280,726	
76%	2%	22%	37%	7%	57%	26%	7%	67%	

Medallion II Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
420,207	-363	419,844

MEDALLION Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
52,173	-222	51,951

Medallion II Pre-Assignment Status

	Number	Percent
Pre-assign:	39,498	100%
Change:	223	1%
Accepted:	39,275	99%

MEDALLION Pre-Assignment Status

	Number	Percent
Pre-assign:	5,072	100%
Change:	544	11%
Accepted:	4,528	89%

Enrollment by MCO*

	This Month	Percent	Change
Optima FC by Optima	122,522	29%	210
Anthem by Penninsula	20,050	5%	187
Anthem by Priority	25,042	6%	146
Anthem by HealthKeepers	97,608	23%	(305)
Virginia Premier	115,736	28%	(301)
CareNet by Southern Hlth	17,234	4%	(73)
AMERIGROUP:	21,652	5%	(227)
Total	**419,844**	**100%**	**(363)**

Program Analysis

	FFS	MEDALLION	Medallion II
Low Inc Families w Children	18,501	6,998	58,736
Aged	42,048	24	227
Blind / Disabled	57,688	480	2,070
Adult SSI	61,190	9,426	33,441
Child SSI	4,907	2,134	16,933
FAMIS Plus	56,313	29,417	279,627
Medicaid Expansion (AC 094)	4,651	3,472	28,810
Total	**245,298**	**51,951**	**419,844**

MEDALLION PCP Availabilty

PCP Physicians (Receiving Fee)	Total Slots Defined	Total Slots Available	Slots Available for Assignment	Eligibles to be Assigned
1,313	656,089	589,843	66,246	2,665

* Includes AC 094 and FAMIS Plus

FAMIS Plus includes: (ACs 072, 074, 075, 076, 081, 082, 083, 085, 086, 088, 090, 092, 093, 098, and 099 where age <21) and (AC 091age where <6).

ATTACHMENT XXIX - CONTINUED

Managed Care Enrollment Report
September 2008

Enrollments - This Month

FFS*			MEDALLION*			Medallion II*			Total
248,493			51,687			420,882			721,062
34%			7%			58%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
185,378	4,768	58,347	19,100	3,483	29,104	111,747	29,021	280,114	
75%	2%	23%	37%	7%	56%	27%	7%	67%	

Enrollments - Last Month

FFS*			MEDALLION*			Medallion II*			Total
245,298			51,951			419,844			717,093
34%			7%			59%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
184,334	4,651	56,313	19,062	3,472	29,417	111,407	28,810	279,627	
75%	2%	23%	37%	7%	57%	27%	7%	67%	

Medallion II Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
419,844	1,038	420,882

MEDALLION Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
51,951	-264	51,687

Medallion II Pre-Assignment Status

	Number	Percent
Pre-assign:	44,168	100%
Change:	470	1%
Accepted:	43,698	99%

MEDALLION Pre-Assignment Status

	Number	Percent
Pre-assign:	5,209	100%
Change:	646	12%
Accepted:	4,563	88%

Enrollment by MCO*

	This Month	Percent	Change
Optima FC by Optima	123,183	29%	661
Anthem by Penninsula	20,066	5%	16
Anthem by Priority	25,248	6%	206
Anthem by HealthKeepers	98,690	23%	1,082
Virginia Premier	116,001	28%	265
CareNet by Southern Hlth	17,299	4%	65
AMERIGROUP:	20,395	5%	(1,257)
Total	**420,882**	**100%**	**1,038**

Program Analysis

	FFS	MEDALLION	Medallion II
Low Inc Families w Children	18,699	7,018	59,069
Aged	42,113	25	239
Blind / Disabled	58,206	516	2,078
Adult SSI	61,354	9,429	33,504
Child SSI	5,006	2,112	16,857
FAMIS Plus	58,347	29,104	280,114
Medicaid Expansion (AC 094)	4,768	3,483	29,021
Total	**248,493**	**51,687**	**420,882**

MEDALLION PCP Availabilty

PCP Physicians (Receiving Fee)	Total Slots Defined	Total Slots Available	Slots Available for Assignment	Eligibles to be Assigned
1,334	659,633	593,822	65,811	2,954

* Includes AC 094 and FAMIS Plus

FAMIS Plus includes: (ACs 072, 074, 075, 076, 081, 082, 083, 085, 086, 088, 090, 092, 093, 098, and 099 where age <21) and (AC 091age where <6).

ATTACHMENT XXIX - CONTINUED

Managed Care Enrollment Report
October 2008

Enrollments - This Month

FFS*			MEDALLION*			Medallion II*			Total
251,261			50,841			421,991			724,093
35%			7%			58%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
186,168	4,986	60,107	18,903	3,423	28,515	111,861	29,233	280,897	
74%	2%	24%	37%	7%	56%	27%	7%	67%	

Enrollments - Last Month

FFS*			MEDALLION*			Medallion II*			Total
248,493			51,687			420,882			721,062
34%			7%			58%			100%
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
185,378	4,768	58,347	19,100	3,483	29,104	111,747	29,021	280,114	
75%	2%	23%	37%	7%	56%	27%	7%	67%	

Medallion II Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
420,882	1,109	421,991

MEDALLION Enrollment

Previous Month	Net Change This Month	This Month's Enrollment
51,687	-846	50,841

Medallion II Pre-Assignment Status

	Number	Percent
Pre-assign:	46,675	100%
Change:	257	1%
Accepted:	46,418	99%

MEDALLION Pre-Assignment Status

	Number	Percent
Pre-assign:	6,377	100%
Change:	833	13%
Accepted:	5,544	87%

Enrollment by MCO*

	This Month	Percent	Change
Optima FC by Optima	123,596	29%	413
Anthem by Penninsula	20,222	5%	156
Anthem by Priority	25,417	6%	169
Anthem by HealthKeepers	99,161	23%	471
Virginia Premier	115,939	27%	(62)
CareNet by Southern Hlth	17,258	4%	(41)
AMERIGROUP:	20,398	5%	3
Total	**421,991**	**100%**	**1,109**

Program Analysis

	FFS	MEDALLION	Medallion II
Low Inc Families w Children	18,627	6,997	59,463
Aged	42,264	25	231
Blind / Disabled	58,478	523	2,041
Adult SSI	61,661	9,324	33,264
Child SSI	5,138	2,034	16,862
FAMIS Plus	60,107	28,515	280,897
Medicaid Expansion (AC 094)	4,986	3,423	29,233
Total	**251,261**	**50,841**	**421,991**

MEDALLION PCP Availabilty

PCP Physicians (Receiving Fee)	Total Slots Defined	Total Slots Available	Slots Available for Assignment	Eligibles to be Assigned
1,324	648,045	583,039	65,006	4,131

* Includes AC 094 and FAMIS Plus

FAMIS Plus includes: (ACs 072, 074, 075, 076, 081, 082, 083, 085, 086, 088, 090, 092, 093, 098, and 099 where age <21) and (AC 091age where <6).

Page 16: [6] Deleted **12/19/2008 3:17:00 PM**

Virginia Acute and Long-Term Care (VALTC) Integration

Virginia Acute and Long-Term Care Integration (VALTC) is an initiative designed to improve the quality of life of Virginia's Medicaid-enrolled seniors and individuals with disabilities. This new managed care system strives to empower qualifying individuals to remain independent and reside in the setting of their choice for as long as possible through the provision of a streamlined primary, acute, and long-term care service delivery system. VALTC offers ongoing access to quality health and long-term care services, care coordination, and referrals to appropriate community resources. Information about the Integration of Long Term Care, including the pilot locality is available on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm.

Currently, individuals who are dually eligible for Medicare and Medicaid, as well as the fee-for-service individuals who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver and are excluded from participating in managed care. (As described in Section 2 above, MCO enrolled individuals, who subsequently become enrolled in the EDCD waiver, maintain their MCO enrollment for acute care benefits and receive their waiver benefits through the Department's fee-for-service program.) These individuals, who are often very frail, currently receive very little assistance with the coordination of their services – and their services are often very complex.

Through VALTC, adult individuals 21 and over who are dually eligible (have Medicaid and Medicare coverage) and/or who are EDCD waiver participants (in certain areas of the Commonwealth) will be able to receive their health care and long-term care services through a coordinated delivery system. (Initially children under age 21 will not be covered under the VALTC program.) These individuals will be enrolled in a new managed care organization (MCO) program that will offer ongoing access to quality health and long-term care services, coordinated benefits between Medicare and Medicaid, care coordination, and referrals to appropriate community resources.

The initial pilot of this new program is slated to begin July 1, 2009 in the Tidewater area for approximately 15,000 dual eligible and EDCD waiver participants. This will require the selected Enrollment Broker to have member materials (comparison charts) developed and printed by April 1, 2009. Additionally, the initial launch of VALTC entails recipients receiving their preassignment letter in May of 2009, (for a July 1, 2009 effective date) therefore the Enrollment Broker must be staffed and ready to respond to VALTC calls no later than May 1, 2008. This program integrates managed care, long-term care, and Medicare when possible, to offer our elderly and disabled participants better coordination and intervention to lead to better health outcomes. The table below provides additional details on the anticipated participation volume of dual eligibles and EDCD participants.

Virginia Integration of Acute and Long Term Care (VALTC) Pilot

Population	Anticipated # of Recipients	Comments
Dual Eligibles *Initial implementation and ongoing enrollment*	**12,000**	**Because this population has Medicare primary coverage, anticipated call volume for Dual Eligibles is expected to be significantly lower than the current Managed Care Volume (see attachment V).**
Dual + EDCD Waiver Participants *Initial enrollment into MCOs*	**1,732***	**See comment below**
EDCD Waiver Participants	**371***	**See comment below**

***Of these categories, approximately 60-80 per month or less than 1,000 per year are considered to be "newly eligible" enrollees. Newly enrolled EDCD individuals represent the only portion of the VALTC population that will require outbound calls in relation to the weekly enrollment process as described in Section 3.10.

Contracted VALTC MCOs will operate under the direction of concurrent CMS 1915(b) and 1915(c) Waivers and under a fully capitated, risk-based, managed care contract. Under VALTC, the MCO will be responsible for the full-continuum of acute and long-term care services. Like Medallion II, however, certain services will be carved-out of the VALTC MCO program and will be reimbursed through the Department's fee-for-service program. The list of VALTC carved-out services is provided as Attachment XV of this RFP.

There are some individuals who are excluded from participating in the VALTC program even if they meet other qualifying VALTC criteria. Examples include full benefit duals who are inpatients in state mental hospitals, individuals who receive hospice services, and individuals who are hospitalized at the time of MCO enrollment. Exclusions may be temporary (example hospitalized at the time of enrollment) or long-term. The full list of exclusions for the MCO VALTC program will be provided to the Enrollment Broker prior to contract implementation.

The Enrollment Broker is the key entity for participant enrollment into the VALTC program. Enrollees and potential enrollees will have access to toll-free assistance through the Enrollment Broker, which will offer a wide range of services related to enrollment decision-making, resource identification, educational materials, additional information on specialty services, identifying special health care needs, translation services and general information. Under VALTC, the Enrollment Broker will be conducting telephone enrollment, including outbound calls, for program participants beginning in July of 2009.

Page 28: [7] Deleted **12/19/2008 3:25:00 PM**

3.10 VALTC MCO Enrollment

Preassignment for VALTC participants, except those who are newly enrolled into the EDCD Waiver, will follow the process described above for Medallion II, and shall be processed by the Enrollment Broker according to the requirements described in Section 3.8. The Department's mailing contractor will send VALTC recipients a preassignment letter, MCO brochure, and VALTC MCO comparison chart indicating the MCO choices available within their locality. VALTC recipients will have the option of changing their preassigned MCO by contacting the Enrollment Broker prior to the effective date of their MCO enrollment. Recipients are also allowed to change MCOs within 90 days of effective date of enrollment into a MCO. Recipients may decide to change to another MCO (where there was no prior assignment to that MCO) and receive another 90 day trial period.

Similar to Medallion II, MCOs are notified of the recipients assigned to their health plan by the Department around the 20th of each month. The MCO sends their newly enrolled members a VALTC MCO packet, including a VALTC MCO identification card, VALTC member handbook, and a VALTC MCO provider directory. The member should receive this information by the last day of the month.

The initial enrollment process for individuals who are ***new to the EDCD Waiver AND who reside in the VALTC pilot area*** shall be handled by the Enrollment Broker through an expedited telephonic enrollment process, including out-bound telephone calls. The volume of newly enrolled EDCD waiver recipients eligible to participate in the VALTC program is anticipated to be between 60-80 per month. This expedited telephonic enrollment process is necessary as VALTC individuals are often frail and in urgent need of services. Events that occur prior to the Enrollment Broker's notification of these individuals is as follows. Individuals are screened for the EDCD Waiver by a Department contracted Preadmission Screening Team. If the individual resides in a VALTC area, and meets EDCD functional criteria, the Screening Team will provide the recipient the necessary enrollment materials (VALTC MCO comparison chart, etc), and the phone number to the Managed Care Helpline. The Screening team will also notify the Department's VALTC Transition Coordinator of these new VALTC EDCD participants.

The Enrollment Broker will be advised of these enrollees through the daily secure email of *New VALTC EDCD Participants*, as sent by the Department's VALTC Transition Coordinator. Upon receipt of this email, the Enrollment Broker shall conduct telephonic outreach activities (up to two out-bound calls – one per-day) to explain the VALTC program and to assist the enrollee in making an informed MCO plan choice. The Enrollment Broker shall enter all VALTC MCO enrollments, according to the recipient's health plan choice, into the VAMMIS within no more than 3 business days of receipt of the email from the VALTC transition coordinator. For recipients who do not respond to outreach efforts within 3 business days, enrollment to a default MCO will be automatically assigned by VAMMIS.

The Enrollment Broker shall assure that all EDCD VALTC enrollments are entered 100% of the time within 3 business days. Additionally, an effort must be made to process enrollments by the weekly VALTC VAMMIS cut-off time frame (every Friday) to avoid an unnecessary delay of the managed care enrollment. The MCO enrollment effective begin date is also VAMMIS generated, and will generally occur within 6-10 calendar days from the Enrollment Broker's date of entry.

Different than other enrollments, MCOs will be notified of their newly enrolled EDCD members on a weekly basis by the Department. For newly enrolled EDCD recipients the MCO sends their members a VALTC MCO packet, including a VALTC MCO identification card, VALTC MCO member handbook, and a VALTC MCO provider directory. The MCOs mail this information to the member within 5 business days of the MCO's receipt of the Department's weekly enrollment report.

Future MCO plan changes will follow the general managed care enrollment process as described for Medallion II (above). The Enrollment Broker shall process requests for future changes to VALTC MCO enrollments, including for existing EDCD VALTC recipients who want to make a change to their assigned MCO, as described in Section 3.8 above.

Page 95: [8] Deleted **12/19/2008 3:43:00 PM**

ATTACHMENT XIII - VALTC EXCLUSIONS

(These exclusions are subject to change prior to the EB Contract begin date.)

The MCO shall cover all VALTC Medicaid eligible individuals, with the exception of individuals excluded from the program in accordance with Federal and State regulations and DMAS guidelines. The Department shall exclude individuals who meet at least one of the exclusion criteria listed below.

Individuals in the pilot areas under age 21, including dual eligibles and those enrolled in EDCD Waiver services, remain excluded from VALTC at this time.

Note: The only exception to the under age 21 rule is for babies born to a VALTC-enrolled participant who will be covered by the VALTC-MCO for the birth month plus two months (a total of 3 months maximum), or until transitioned to a Medallion II MCO (if applicable), or whichever occurs first.

b. Individuals who are inpatients in State mental hospitals.

Individuals who are institutionalized (State Hospitals; ICF/MR facilities; Residential Treatment Facilities; long stay hospitals; existing nursing facility participants at the implementation of the VALTC program).

Individuals who are placed on spend-down.

Individuals who are participating in the family planning waiver, or in federal waiver programs for home-and-community-based Medicaid coverage (excluding EDCD).

Individuals who are participating in foster care or subsidized adoption programs.

Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician, midwife, or hospital) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid and the VALTC program.

Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO.

Individuals who are enrolled in, or enter a Medicaid-approved Hospice program.

Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).

Individuals hospitalized at the scheduled time of enrollment. The exclusion shall remain effective until the first day of the month following discharge.

Individuals who request exclusion during assignment to an MCO, or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy.

Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC §1471 et seq.) who are granted an exception by DMAS to the mandatory enrollment.

Individuals who have an eligibility period that is less than three months.

Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program.

Individuals who have an eligibility period that is only retroactive.

Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

Individuals enrolled in the Children's Mental Health Waiver.

Individuals enrolled in the Money Follows the Person (MFP) Demonstration Program.

Individuals enrolled in the Technology Dependent, Mental Retardation, Individual and Family Developmental Disability, Alzheimer's, HIV/AIDS, and Day Support 1915(c) Waivers.

Individuals outside of the pilot areas will be excluded from the VALTC program at this time.

Individuals enrolled in a PACE program.

Individuals enrolled with a VALTC MCO that subsequently meet one or more of these criteria during MCO enrollment shall be excluded as appropriate by DMAS. Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

The Department shall, upon new State or Federal regulations or Department policy, exclude other individuals as appropriate.

Page 105: [9] Deleted **12/19/2008 3:43:00 PM**

ATTACHMENT XXII - VALTC LOCALITIES AND SPECIFIC SERVICES

VALTC will be initially offered in the Tidewater area beginning July 1, 2009. For the Tidewater launch, prospective managed care organizations (MCOs) will contract for all targeted populations in the core localities. MCOs may include the provision of services for any or all of the non-core localities. DMAS, however, must have a minimum of two MCOs in each locality in order to implement the program. VALTC covered localities for Tidewater are as follows:

Tidewater (July 1, 2009)

FIPS	TIDEWATER
CORE LOCALITIES	
550	**Chesapeake**
650	**Hampton**
700	**Newport News**
710	**Norfolk**
740	**Portsmouth**
800	**Suffolk**
810	**Virginia Beach**
NON-CORE LOCALITIES	
073	**Gloucester**
093	**Isle Of Wight**
095	**James City County**
199	**York**
735	**Poquoson**
830	**Williamsburg**

VALTC Long-Term Care Services Included in the MCO Contract
(in addition to primary and acute care services)

Adult Day Health Care
Personal Emergency Response System
Personal Care (Provided by an agency or consumer directed)
Respite Care (Provided by an agency or consumer directed)
Service Facilitation (to assist individuals who wish to consumer direct services)
Assistive Technology
Environmental Modifications

VALTC Dual Eligible Services Included in the MCO Contract

Coinsurance, copayment, and deductible for Medicare-allowed services (i.e., “crossover claims”).
Medicaid-covered services (including certain medications), even those that are not allowed by Medicare.